

ADOLESCENT SUBSTANCE ABUSE: BARRIERS TO TREATMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON
CHILDREN, FAMILY, DRUGS AND ALCOHOLISM
OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

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FIRST SESSION

ON

EXAMINING ALCOHOL AND OTHER DRUG ABUSE TREATMENT OF
ADOLESCENTS

MAY 2, 1989

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ADOLESCENT SUBSTANCE ABUSE: BARRIERS TO TREATMENT

TUESDAY, MAY 2, 1989

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN,
FAMILY, DRUGS AND ALCOHOLISM, OF THE
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:12 a.m., in room SD-430, Dirksen Senate Office Building, Senator Christopher J. Dodd (chairman of the subcommittee) presiding.

Present: Senators Dodd, Adams, and Coats.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. The Subcommittee on Children, Family, Drugs and Alcoholism will come to order. I want to welcome all of you here this morning to the subcommittee.

Senator Coats and I had the pleasure this morning, along with many other people a couple of hours ago, of watching a program that will be aired on HBO that deals with adolescents and how to try and deal with substance abuse problems, not just drugs but alcohol as well, of children. And I want to commend, publicly, Home Box Office for putting together this film. It will be shown, and available to parent-teacher organizations, schools and the like, and there is a strong effort underway to make it available absolutely free of charge to school systems to help teachers and parents, principally parents, understand some of the jargon, what to look for, what signs, where to go for treatment and help, and the like. It is a very fine effort—one of a series of programs that HBO intends to produce for public broadcast and to make available, again, to parents and teachers, and obviously to young people as well, to help deal with the growing problem of substance abuse in this country.

We now turn our attention to the treatment of adolescent drug abuse and addiction. Let me begin by trying to put this issue into context.

The 1986 and 1988 drug bills established a dual strategy, as you will all recall, to combat drug abuse: Law enforcement and interdiction to turn off supply; and prevention, education and treatment to shut down demand. Of the two, decreasing the demand is the less flashy, but without doubt the more fundamental side of this equation. For as long as the demand for drugs persists, new supplies from new suppliers, via new routes, or in the form of new products will emerge and unfortunately prevail.

As a side note, I would mention that this past weekend, a delegation of House and Senate Members met once again for the 29th time with our counterparts in the Mexican Congress. I would say about 50 percent of that conference, over 4 days, was devoted to the issue of drug supplies coming out of Mexico. And while we have seen tremendous improvement under the new government of President Salinas in the last 5 months—reflected, I might add, in a letter that was signed by 68 Members of the Senate to President Salinas, commending him for some of the steps that have been taken—it was agreed by all that a lot is left to be done. But one of the points that is made by our colleagues in Mexico, and one that many of us agree with, is that while they have to do a better job of cutting down the production, supply, and the trafficking of drugs that come from Mexico—and other places. And the facts are, as we have seen in the past in a nation like Turkey, which was a major supplier of drugs, while the Turkish government did a tremendous job in eradicating and eliminating the supply problem in their country, it just re-emerged someplace else.

So even if Mexico, which has been a major source of difficulty, were to be 100 percent effective in dealing with the supply, trafficking, and production in their country, as I have just suggested and others will tell you, the problem does not end because it just re-emerges some other place. The only way to effectively deal with that in the long term is, of course, our own demand.

So we must attack the demand, and that means we have to reduce drug profits, educate parents and children, and prevent new users as well as rehabilitate current abusers. It also means we put demands on the drug users, making them take the personal responsibility to quit. But in order to do this adequately and appropriately, directed treatment systems have to be in place.

Now that the drug bills have been enacted, it is time to focus on the key groups within the overall population of substance abusers. Drug users are not heterogeneous. They have different needs and problems; generic outreach and treatment plans will not work.

We have to identify the important subgroups and separately target them with the specific, directed education and treatment programs. We need to know how each subgroup is vulnerable, how best to reach them, and what methods work best.

We focus on adolescents today because they constitute an especially pivotal and distinct subgroup. For one, they are more vulnerable. Behavioral and psychological studies show that they are intoxicated at lower doses and become addicted more quickly. Youths are also experimenting with drugs at ever younger ages—when their beliefs about addiction and their own invincibility are even more naive.

Data on 6,000 Connecticut students in grades 7-12, surveyed between 1987 and 1988, show that 57 percent currently are drinking alcohol and that 11 percent are smoking marijuana. By their senior year, 83 percent are drinking alcohol, 23 percent are using marijuana, and 1 in 5, or 25 percent, have tried cocaine.

Second, substance abuse is especially destructive for adolescents. They are at a critical time for character development and making choices, the consequences of which are often lifelong. The leading cause of death for young Americans between the ages of 16 and 24

is alcohol-related automobile accidents. Eleven teenagers die each day—in this country—in alcohol-related accidents. Suicide is the second leading cause of death in this age group.

Adolescent addiction means immense waste, lost potential and personal tragedy, wrecking valuable, soon-to-be-productive lives on the verge of adulthood.

Last, adolescents are America's immediate future, and that is obviously self-evident. Their drug abuse has consequences that go beyond their individual losses. The violence resulting from youth and drugs threatens our school systems and the safety of our neighborhoods.

New York City Board of Education blames drugs, particularly crack, for a 10-percent increase in the number of weapons confiscated in schools this year. They estimate that 1,650 weapons will be taken this academic year alone in that city. Although the size of the juvenile population is shrinking, the number of confined juveniles increased 10 percent between 1983 and 1987. Total annual costs for State and local juvenile facilities went up 32 percent to a total of \$1.46 billion between 1982 and 1986.

In fact, before us here are some charts, and once again we challenge the eyesight of our audience, but they should be available down there for you. The first shows the types of offenses and the reasons for which male and female juveniles were held in juvenile facilities between 1985 and 1987. And rather than go through all the numbers, the first line is the total juveniles, and they break it down between male and female, between 1985 and 1987. In 1985, there were 49,900 juveniles that were being held in public juvenile facilities. In 1987, that number had jumped to almost 54,000; just in that 2-year period, we have seen that kind of an increase. We are seeing the same increase in juvenile offenses, and it is broken down between violent, where it has increased from 6,000 to almost 8,000; manslaughter, simple assault, and sexual assault has increased from 3,500 to almost 6,000 just in that 2-year period. And again, I point out that this is while you are watching a juvenile population shrink in numbers. So it is important to take these numbers not just as a normal increase, but a shrinking population overall.

Alcohol and drug offenses in relation to all of this, from 1985, where we had 2,660, have increased to now over 4,000 in that same category.

So the numbers are clearly moving in the wrong direction. And although, as I said, the size of the population has been shrinking, juveniles confined in facilities has gone up 10 percent. Ninety-four percent of these juveniles were held for criminal-type offenses. Eighty-six percent were male, and 82 percent were between the ages of 14 and 17 years of age. The number of juveniles held in 1987 for alcohol or drug offenses has increased by more than 50 percent since 1985. The total annual cost for State and local governments operating juvenile facilities, as I said, reached \$1.46 billion between 1982 and 1986.

Drug treatment costs—we obviously focus our attention on the loss of a life, the loss of ability to perform—and obviously, those statistics, no one can put a number that is adequate on them. But to put it in terms of some people who seem to be impressed with dollars-and-cents numbers, let me share a couple of them with you.

For example, no treatment—crime, death, suffering, loss of productivity, increased health care costs, spread of AIDS, which is obviously related.

Economic costs to society of alcohol and drug problems—according to an RTI study, for fiscal year 1983 it was \$176.42 billion; incarceration, the average cost per person per year is \$14,500; and treatment, the average cost per person is approximately \$5,000.

So when you start to look at these numbers and look at the incarceration costs, the treatment costs, and the loss overall to society, and then you look at the numbers that we come up with in terms of drug treatment and education, while certainly, the focus has shifted—and I commend my colleagues for it—where in the past we found the bulk of the money going for the judicial side or the police efforts, which are obviously necessary, today we are looking at the last bill, where 60 percent of the funds are going for treatment and education and 40 percent on the police or the judicial end of the equation. Again, it is a modest amount. We are talking about \$5 billion, which is a lot of money, but I was thinking last week, when we came up with \$160 to \$200 billion to bail out the savings and loan institutions, no one asked the question, or at least it was not paramount: Where is the money going to come from? We all knew we had to deal with it, because we had failing thrifts and people who were losing their deposits. Well, I would suggest to you that while it is expensive and costly to come up with programs, and I certainly sympathize with that and with our deficit problems, and we have got to be sensitive to it, it is costing us a staggering amount of resources not to mention the lives that are being lost and society being shredded by this problem. And we have got to talk about it not just in terms of drugs but alcohol as well. The problem is we tend to focus just on the drugs and not look at the alcohol side of this.

So the problem is one that demands, it seems to me, to be put in a proper priority sense. If we can manage to do the \$160 to \$200 billion for savings and loan institutions, you cannot convince me we cannot do a better job of convincing people that we need to make this at least as important a priority.

Clearly, adolescent substance abuse is as critical as it is distinct. It is my view that we need to develop adolescent-specific treatment programs and approaches, and the Federal Government needs to understand this. Unfortunately, only two Federal health programs are directed toward adolescents at the present. One is the Adolescent Family Life Program. The other, which I am pleased to say was an initiative that came out of this committee, is the High-Risk Youth Projects, directed by the Office of Substance Abuse Prevention.

We also need to identify and remove the major obstacles to rehabilitation. We will hear today from providers, program directors, parents and adolescents about many different barriers to treatment. Some are organizational—the lack of coordination, the shortage of facilities, the gaps in insurance. Others are social. Some communities, for instance, oppose having any treatment centers in their midst. And then there are the behavioral barriers like denial by both adolescents and their parents. And there is the adolescent mentality itself, which may be mercurial, volatile, and impulsive.

Now, before we get started, I would like to thank the witnesses this morning who are here with us. I am looking forward to coming away from today's hearing with a better appreciation and understanding of the problem and how we should try to deal with it.

I should point out as well—and we will hear this later this morning—but just going over the testimony, one statistic, Dan, that just stuck out incredibly to me is the number of slots for treatment in this country. I think there are roughly 250,000 slots available for drug treatment, and yet the number of people that would need those drug slots is now in excess of 6 million people in this country. So even when you get a child or a family who come to the most important crossroad—and that is, "I need help"—and parents who recognize it and kids who step forward and say, "I need your help and your love, and I have got to do something about this"—the fact of the matter is that for an overwhelming number of them, they have to wait months before they may ever qualify to get into a treatment program. So the danger of losing a child, slipping back into the abyss of drug abuse or alcohol abuse, is significant when you have only so many slots available and the staggering number of children who need that kind of help.

So this morning, we hope to highlight those specific questions.

Let me turn, if I may, to my ranking minority member, who has a deep interest in this subject matter and I know has some witnesses as well who have come this morning from his own State, I believe, and others who care about these issues. Senator Coats.

OPENING STATEMENT OF SENATOR COATS

Senator COATS. Thank you, Mr. Chairman.

I have particularly looked forward to this hearing because of concerns and convictions that I hold about what drugs are doing to our society, to our families and especially to our Nation's young people.

During the more than 8 years that I have served in the Congress, I have spoken to dozens, perhaps hundreds, of groups, community organizations, parents' groups, parent-teacher organizations, schools, school classes and others about what I believe is this country's most pressing problem—abuse of drugs and alcohol—and how they have contributed to the breakdown of the family.

Just last week, I travelled throughout much of Indiana, speaking on this very theme to chambers of commerce, rotary groups, and several organizations in different cities in Indiana. I also visited two drug treatment facilities in Indiana; one, a rural facility in Batesville, IN, called Serenity House, and another, a suburban/urban treatment facility in the city of Indianapolis, called Fairbanks Hospital. I saw there, firsthand, the terrible grip that drugs and alcohol abuse can have over an individual and the chaos that addiction creates in their families.

That is why I am particularly interested to learn more from today's hearing not only about why individual dependency is often symptomatic of deeper family problems, but about how involving the family in therapy can also be part of successful treatment.

I am also especially pleased that Dr. Robert Lewis from my own State could come and testify before the subcommittee this morning. Dr. Lewis is one of a team of experts from Purdue University who

have received a 5-year grant from the National Institute of Drug Abuse to develop a family-based therapy program, treatment approach, to curb adolescent substance abuse. He brings a unique perspective rooted in several years of studying the treatment of young people who have drug dependency problems, and extensive research and counseling in marital and family relations.

The drug crisis that this country now faces goes well beyond the murder and mayhem we read about daily in the newspapers. Drugs are also part of other societal problems—illiteracy, crime, delinquency—problems that aren't just restricted to large cities like Washington, DC, but reach into every community in this country.

As the film we viewed this morning at breakfast to well, but so disturbingly revealed, there are few adolescents today that have not been exposed to drugs and even at incredibly early ages.

In addition to speaking out about these concerns, I am also looking forward to serving on the National Commission on Drug-Free Schools and working with Home Box Office, Chairman Dodd, and my Senate colleagues to distribute as widely as possible the eye-opening film we saw this morning: "How to Raise a Drug-Free Child."

Mr. Chairman, I also look forward to working with you on these important treatment and prevention issues. There is much work to be done, but I think we are moving in a positive direction by scheduling these hearings and having such excellent panelists as we have today.

Certainly there are few problems as pressing in this Nation as the problem of drug abuse and how we deal with it. I agree with the chairman that it is not just a supply side problem. We have directed considerable efforts in the past at eradicating supply, and we must continue to do so at interdiction, and we must continue to do so at law enforcement. But the real war on drugs will be won on the demand side, because suppliers will continue to find ways. There just simply are not enough countries that we can go in and work cooperatively with to stop the supply. There are too many miles of coastline, too many ingenious ways of bringing drugs into this country for us to interdict.

And while I say we need to do everything we can in that area, it is only when we dry up demand that we will dry up the drug problem in this country. So we do need to continue to focus our efforts on treatment, on education, on working with our families, with our young people, with all elements of this society, in getting to the point where we have a drug-free atmosphere in our schools and shops and businesses and homes and neighborhoods, and where people will say "no" to drugs.

So this is an important step in that process. I look forward to hearing from our witnesses, and thank you for your interest in this important subject.

Senator DODD. Thank you very much, Senator Coats.

Our first witness this morning—we are delighted she is with us—is Dr. Elaine Johnson. She is director of the Office for Substance Abuse Prevention, or OSAP, in the Department of Health and Human Services. Her job is to identify barriers to treatment for adolescents. Many community programs that rehabilitate adolescents are lost because treatment slots are unavailable—I have men-

tioned that statistic. She will describe the lack of family trust in counselors and the Medicare system, insurance, knowledge about available programs, and a variety of other things.

Doctor, I had the pleasure of sitting next to you at breakfast this morning. We did not get much of a chance to chat with the movie on. You have about a 12-page statement for us here. I am going to ask you to paraphrase those remarks, because we would like to keep the formal statements brief. Your total written remarks will be included as part of the record. But so that we might get to questions, why don't you go through and highlight some of the major points that you think would be worthwhile for the public testimony here, and then we can get to our questions.

STATEMENT OF DR. ELAINE M. JOHNSON, DIRECTOR, OFFICE FOR SUBSTANCE ABUSE PREVENTION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD

Dr. JOHNSON. Thank you, Mr. Chairman, and members of the committee, for inviting me to participate in this very important hearing. And we really want to commend you for your commitment, dedication, and attention to this very important problem facing our country. I will be discussing some of the barriers to adolescent treatment and how the Office for Substance Abuse Prevention is attempting to address them.

In the substance abuse area, I think we have to keep in mind that treatment is part of a continuum of care that includes primary prevention, education, early intervention, treatment and rehabilitation, as well as aftercare. All of these stages of care serve to prevent drug abuse at the various levels of abuse and must address the problems which might trigger, sustain or result in a relapse of substance abuse.

Therefore, we also must recognize that these are very complex factors, and in order to address them effectively, we must then develop a very comprehensive approach, and that is what we promote at the Office for Substance Abuse Prevention.

Now to the barriers. In terms of services, we tend to focus on three areas: availability, accessibility, and acceptance of services.

In the availability area, the point already made in your statement is that many communities do not have sufficient adolescent treatment programs and facilities to serve the number of adolescents needing treatment when they need it. Also, as you may recall historically, the substance abuse field developed around adult treatment. But the demographics have changed, and certainly that was true in the film that we saw this morning, in that many young people begin using drugs at such an early age and become so involved, resulting in their addiction. Therefore, we need many more treatment programs in our country to address this need. Clearly, in many communities around the country, that is just not available.

Related to availability, of course, is accessibility.

Senator DODD. Am I right in those numbers, by the way? The statistics I have are 250,000 slots nationwide and a population area that would qualify or should get some treatment in the neighborhood of 6 million.

Dr. JOHNSON. That is about correct in terms of those who are in need, but you are talking about both adult and young people in those numbers.

Senator DODD. OK.

Dr. JOHNSON. And the point I was making is that the 250,000 that you talked about, a good number of those are for adults who are in treatment. And what we need are more treatment services available for both groups—for adolescents as well as adults.

Related to availability, of course, is the accessibility of these services. You talked about public treatment slots. There are also private programs that provide services. But unfortunately, not too many families in communities are able to afford the services that are put forth by private providers. Many families do not have health insurance, and those who do have insurance, some of the policies do not cover substance abuse treatment. Therefore, the family might then believe they cannot afford treatment because many families are not savvy enough, even if the treatment is available, to obtain treatment services that do not require financial resources or that are on some sliding scale.

In addition to that, we must look at the logistics of the treatment services and where they are located in the community. This is particularly important for rural areas where people living in rural areas are not as accessible to treatment services as we might like for them to be.

And finally, in terms of acceptance of treatment, I think you brought out some of these factors in your opening statement, that you have to look at many factors in regard to treatment. Certainly, areas like cultural factors relate to barriers for treatment. For example, if you look at some of the multicultural groups and their attempts to obtain services, that may present a barrier when the services are not offered in a culturally relevant fashion.

Also, the involvement of the family is very important, and in many of the multiproblem families that we deal with, they do not have the nuclear family that we are more familiar with, and therefore, many significant others also may need to be enlisted in their treatment.

And the different lifestyles of some of the families—I think we have to look at issues whereby unfortunately, the young child's involvement themselves in the trafficking of drugs plays a major role in the economic basis of that family.

So there are many varied issues that we have to take into consideration in providing treatment services, to make them not only available but accessible and also acceptable to the community.

What we attempt to do, then, at the Office for Substance Abuse Prevention is to address as many of these factors as we possibly can. Our approach, then, is a very comprehensive one in that we believe that the family, the school, the community, the economic system, the law enforcement system, both the public and the private sector, need to be involved to address this issue effectively.

In addition, in looking at the service system we must realize that individuals and families are not broken down into compartments as are service delivery systems, so therefore the system must be a very coordinated one. What we have attempted to do, then, with

our programs for high-risk kids is to emphasize and use that as a requirement that the program offer very comprehensive services.

For example, in our High-Risk Youth Grant program, we require that multiple risk factors be addressed in the program. In our Pregnant Addicts program, we require that it be a component of a very comprehensive system and that many of the social service agencies involved must be coordinated to develop very innovative outreach strategies so that we can bring these women as well as their youth into treatment.

Our third program, the Community Youth Activity program, is really targeted to school dropouts. And what we are requiring there is that the entire community be involved to assess this problem. That means that the community has to develop a very comprehensive plan and strategy to focus on this particular problem. We are very concerned about high school dropouts because if you look at the high school senior survey that is done every year, the most recent one points out that a good number of these students are not in school, and we know from other surveys that youths who are not in school have much higher rates of drug use than those who are.

We have a learning community concept, whereby we bring together researchers, clinicians, practitioners, people from the community as well as policymakers, to try to focus on some of the issues that relate to the three factors that I mentioned before in terms of the availability of services, the accessibility of services, as well as the acceptance of services, to see how we can address them more effectively in our programs.

Finally, in the President's budget, there is a proposal for a \$35 million program that would bring together the entire community across the country. There would be some 100 to 150 grant programs where the entire community, in a very comprehensive fashion, could come together and address the problem.

The final point I want to make, because we believe so strongly that there should be a comprehensive approach, is that we at the Federal level attempt to be a role model. And we have joined with other departments within the government to address the problem and work with the various communities. We work very closely with the Department of Labor, Department of Justice, Department of Housing and Urban Development and the Department of Education to develop a very comprehensive approach to the problem. We are going into various communities across the country now, together, to see how we can more adequately address the problem.

In closing, let me say this, that by holding this hearing, you have encouraged me and millions of others who are fighting, to save a generation of Americans from the ravages of drug abuse. We must provide for them the environment and opportunity to learn and thrive that we have enjoyed, and by removing these barriers to treatment, assure that their minds and bodies are healthy so that they can meet the challenges of adulthood and become productive citizens. Thank you again for inviting me to participate.

Senator DODD. Thank you very much, Dr. Johnson.

[The prepared statement of Dr. Johnson follows:]

PREPARED STATEMENT OF DR. ELAINE JOHNSON, PH.D.

I am pleased to appear today before the Members of this Subcommittee, who have demonstrated time and again their dedication to improving the welfare of American children, to address what we in the prevention education arena find as the barriers to treatment of adolescent substance abusers. Many of the problems that create barriers to treatment are the very same problems which lead adolescents to use substances in the first place. Those adolescents most at risk for abusing alcohol and drugs are most at risk because of other problems. And those problems are what we in the substance abuse prevention field are trying to identify and address in developing effective prevention education programs.

In the prevention arena, treatment is just one part of the continuum of care that includes primary prevention and education, early intervention and treatment, and rehabilitation and aftercare. So all of these stages of care serve to "prevent" drug abuse at the various levels of abuse and must address the problems which might trigger, sustain, or result in a relapse of substance abuse. Treating substance abuse without treating the problems that contributed to the abuse of substances in the first place is not effective. To address all of these problems, a comprehensive approach to prevention is needed. The Office for Substance Abuse Prevention recognizes this and seeks to tear down the barriers to successful prevention--or treatment--of substance abuse by promoting a continuum of care and a comprehensive approach to prevention. OSAP further seeks to identify problems that surface as barriers to prevention and treatment.

What are some of the barriers to treatment and how can we eliminate them? Some barriers are evident. Many communities do not have sufficient adolescent programs and facilities to serve the number of adolescents needing treatment when they need it. Services need to be geared to the special needs and perceptions of young people, delivered in an atmosphere which is nonthreatening, nonstigmatizing, and highly supportive. Timing is very important. An unavailable treatment slot may result in losing the chance to treat the adolescent altogether or in delaying treatment to a point in time where treatment farther along in the continuum of care

cycle may be necessary, with more intense treatment and more extensive aftercare.

Other barriers to treatment are more subtle. Perceptions of adolescent substance abusers and their families of their ability to access health care of any kind may, in itself, be a barrier. Is treatment accessible and acceptable? Does the family have health insurance? Does it include coverage for substance abuse treatment? If not, does the family believe it can afford such treatment? Is the family savvy enough to try to get help without financial resources or seek them from social services or other sources?

Attitudes are another problem. Does the family trust the medical establishment? Would the adolescent and the family be embarrassed to seek such treatment, thereby admitting a problem which the family may view as disgraceful? In many cities, and even in rural areas, ethnicity plays a large part in acceptance of treatment professionals. Blacks may be skeptical of being treated by white professionals, Hispanics by blacks, Haitians by Asians, who do not understand "where they're coming from." The barrier may be logistical, such as a lack of transportation, a very real impediment in rural areas. Or, treatment may only be available across town, in an unfamiliar area to which the family would feel uncomfortable traveling. Not only would they have to go through a traumatic ordeal, but do so in a strange place with strange people. These are all examples of barriers to accessing treatment.

But barriers are not limited to access. Barriers are also evident in a substance abuser's ability to benefit from treatment being received. As I mentioned earlier, a substance abuse problem very often coexists with at least one and, often, many other problems. Treating these problems in order to effect successful substance abuse treatment requires comprehensive intervention. Adolescents who have gained access to substance abuse treatment may need to be "treated" in other areas as well. Finding out what other areas need to be addressed must be part of the treatment protocol.

For example, treatment of alcohol abuse in a teenager may not be successful if the child's parents are abusers who go untreated. Or ethnic acceptance of drinking, as a marker of reaching manhood, for example, may have to be addressed and attitudes may need to be discussed with not just the child, but with the family as well.

Emotional disabilities or poor emotional development may have created problems in the child's ability to cope with what others might perceive as ordinary life stresses, leading to substance abuse as self-medication to reduce stress. Such disabilities, likewise, must be treated. Coping skills must be taught to the child so that he or she can deal with unpleasant real life situations without relying on alcohol or drugs.

The barriers to successful treatment may be financial, not as regards access to health care, but in the economic and social standing of the abuser and his or her family. Drugs may be a way

to escape the everyday harsh realities of poverty--poor living conditions, lack of opportunity in education or employment, or the inability of a socially conscious teenager to buy the latest fashions. In some cases, drugs have become a way for children to escape poverty altogether. Participating in drug dealing may afford a child and his or her family the opportunity to make enough money to buy their way out of poverty, and quickly. The sums of money that a child can make as a dealer or simply as a neighborhood crack house scout watching for the police far exceed the amount he or she could earn delivering the Washington Post or flipping hamburgers at the local MacDonalds. In these cases, the child may be more addicted to the dollar than to drugs. This problem, too, must be addressed to make treatment successful over time. Comprehensive treatment must address the motives for abusing drugs, must provide motives for staying drug free that are accepted as more rewarding, and must provide the ways and means for youth to internalize those motives--make them believe, for example, that quality education and a decent standard of living are real, attainable alternatives.

Many children using drugs and alcohol lack the self esteem necessary to believe that they could succeed, be it academically, vocationally, or interpersonally in satisfying relationships. These children require counseling to help them develop healthy attitudes about themselves. Often, the entire family must take part in this counseling to learn how to interact in supportive, positive ways.

This holistic approach to treatment requires professionals versed in treating problems in many different social systems-- the family system, the school system, the community system, the economic system, and the law enforcement system. Treatment--and the entire continuum of care in prevention--must involve all sectors of the community, both public and private, in a coordinated fashion. Schools, health care providers, social services, juvenile justice and law enforcement, civic organizations, religious institutions, housing authorities, and other key agencies must all work together in structured, formalized relationships within the community to provide the services necessary, remaining flexible and fluid enough to accommodate those cases that might otherwise "fall between the cracks."

The Office for Substance Abuse Prevention has programs that focus on all these barriers to treatment. OSAP's high risk youth grant program, in its new FY 1989 cycle, gives priority to programs that address multiple risk factors--personality traits, environmental influences, and behavioral variables-- at different environmental levels. The goal is to design and test programs that respond in a more global manner to the complex and often interrelated factors that may lead to drug abuse in adolescents. OSAP expects to fund about 30 to 35 new projects in FY 1989.

The new grant program for pregnant addicts and their infants supports community-based programs, particularly those that provide

or coordinate a comprehensive service delivery approach, and educational activities to increase awareness of the risks of alcohol and other drug use during pregnancy among women of child-bearing age, including adolescents. OSAP expects to fund 20 to 25 of these new projects in FY 1989.

OSAP's community youth activity program focuses on establishing innovative drug and alcohol prevention services primarily for youth who are not in school, who are at risk of dropping out, or who are involved with gangs. The program has three distinct components: projects of national significance, block grants to the States, and competitive State grants. The projects of national significance will be contract activities designed to address issues that have significant impact on substance abuse problems nationwide. The block grant funds will, by law, be divided equally among the states, with each receiving about \$68,000. These funds will allow states to provide collaborative and coordinative efforts. The \$15 million in competitive grants will be awarded to states based on demonstrated need, the innovative and/or comprehensive scope of their plan, and the commitment to long term solutions. The states are required to obligate awarded funds in accordance with the approved plan.

OSAP's \$3.5 million national training initiative is to be a multifaceted effort to provide continuing education in substance abuse prevention and treatment courses for counselors, health and allied health professionals, social workers, and community organization

personnel. Training will initially be targeted to training of trainers among State level staff from a variety of disciplines, for example, substance abuse, juvenile and criminal justice, education, housing, and government. Subject matter will range from basic prevention principles to more sophisticated state of the art research and theory to specialized information to guide primary care practitioners.

The President's 1990 budget proposes a new \$35 million effort to support the formation of public/private sector partnerships in individual communities across the Nation to develop programs for substance abuse prevention and treatment. This program would support grants to 150 to 200 communities to establish the effectiveness of community coalitions of organizations representing parents, schools, academia, business, industry, and professional organizations in the planning and implementing comprehensive prevention programs. Drawing upon the knowledge base developed in recent years, communities will design long-term approaches that meet the needs of their particular locality. Mainstreaming drug and alcohol services into the general health care system will be encouraged.

OSAP's relatively small, \$1 million conference grant program will provide funds for the networking and information sharing activities that are vital to this relatively new field. The grant announcement, issued in February, is targeted toward service-oriented constituency groups which share mutual interests with OSAP

relating to community consensus building, leadership, and advocacy of national goals.

OSAP is particularly concerned that the demonstrations it sponsors through its grants programs provide replicable prevention approaches. To determine how feasible replication would be, OSAP now requires all of its demonstration projects to include an evaluation component, with 15 to 20 percent of the grant funds designated to support the evaluation. In addition, OSAP is supporting major program-wide evaluations of each of the programs described. A 3-year, \$3 million evaluation contract for the first of the OSAP demonstration programs, the high risk youth grant program, was awarded in the summer of 1988. Similar contracts will follow as new programs are funded.

We in OSAP are excited about the strides we are making toward identifying barriers to prevention and treatment of adolescent drug abuse. One of our demonstrations is doing what no other research or demonstration programs have done before--studying the differences of ethnic backgrounds and how these relate to barriers in prevention and treatment. Previous programs have usually dealt with white middle class adolescents. This particular project is working with Japanese, Korean, Filipinos, Cambodians, and Vietnamese.

OSAP is also profiting from our Learning Community, which consists of grantees, researchers, and representatives from State agencies

and National organizations concerned with youth at high risk for the use of alcohol and other drugs. OSAP established this entity to facilitate the sharing of information and development of community networking on high risk youth issues. At the Second Annual Conference, held in Washington, D.C., on December 12 to 14, 1988, participants split into groups by area of interest, grantees clusters. One such cluster, the Rural Program Cluster, surfaced many issues which need to be further addressed to allow successful prevention and treatment of rural adolescents. For example, they found that the relative isolation of rural youth often leads to a feeling of a lack of opportunity, resulting in less motivation toward academic and vocational goals and lowered expectations of the individual and family. Isolation also affects the ability of such areas to recruit and retain trained substance abuse professionals. These are both barriers to prevention and treatment that need to be addressed. And by sponsoring such forums where the experiences and knowledge of professionals can be shared in a supportive environment, OSAP can make further inroads to eliminating barriers that may be quite prevalent, but have not yet been addressed.

Another barrier to treatment, particularly for the multi-ethnic, lower-income groups is the existence in the United States of a two-tier treatment system, where private treatment programs have available treatment slots, provide quality care, but are beyond the financial means of many abusers. Meanwhile, public treatment facilities often are affordable or free, but have long waiting

lists and may not provide the level, type, or length of treatment best indicated for a particular abuser's needs. Obviously, these problems are barriers to all substance abusers, not just adolescents. But they are particularly relevant for this group of people, many of whom have not yet entered the work force, are not well prepared to do so, and have no income of their own. These kids are highly unlikely to be able to walk into the adolescent equivalent of a Betty Ford Center, even with their parents' assistance, assuming they are living at home and have parental support.

By holding this hearing, you have encouraged me and millions of others who are fighting to save a generation of Americans from the ravages of drug abuse. We must provide for them the environment and opportunity to learn and thrive that we have enjoyed and, by removing these barriers to treatment, assure that their minds and bodies are healthy so they can meet the challenges of adulthood.

Senator DODD. Dr. Johnson, how much of a budget do you actually get in total? What are we talking about here?

Dr. JOHNSON. The total budget for fiscal year 1989 is \$69,853,000.

Senator DODD. I am particularly interested, as you know, in the High-Risk Youth Program. That is one that I had authored as part of the drug bill as one of the two programs to target funds particularly to the high-risk youth, the kids who aren't in the school programs or other places that can be a part of this particular effort.

I wonder if you might elaborate on the programs directed toward the multiple high-risk factors in particular.

Dr. JOHNSON. Let me point out that this year, in fiscal year 1989, we have \$17 million in continuations, and for the new programs that we will be awarding by the end of this fiscal year, there is \$7 million, which will fund about 30 to 35 new programs. The legislation that you speak to was very helpful in that it was very comprehensive in directing our attention to a multitude of risk factors. These risk factors, in addition to the ones you have mentioned for dropouts or youth who are in danger of dropping out, also dealt with children of substance abusers, whether they are alcoholics or other drug abusers, economically disadvantaged youth, youth who are already caught up in the juvenile justice system or who have begun already using the gateway drugs, alcohol, cigarettes, and marijuana.

What we have attempted to do in those programs, then, is to reach youngsters who unfortunately the prevention messages had not reached, or if they reached them, they were not effective in deterring their drug use. Many of these families are multiproblem families.

We have some 130 programs across the country, and they deal with all of these multiple issues. Some deal with homeless kids, some deal with teenagers who are parents themselves. What we attempt to do, then, is to develop innovative prevention, early intervention as well as treatment approaches to address the problem. And what we are then pushing these programs to do is to look at the problem very comprehensively and address them.

Now, these programs are now just in their second year, so we cannot give definitive results, but let me tell you that some of the early results that we have are very promising. For example, we have one program with the Boys' Club. The early, preliminary findings are showing reductions in not only drug use, but vandalism and thefts and also reductions in suspensions from school.

So we are very optimistic about the program.

Senator DODD. When do you expect to have some results that you might be able to share with the committee on how that is working?

Dr. JOHNSON. We have a contractor that is looking at all of these programs and doing cross-site evaluations, and we would hope that close to the end of this calendar year, we will have some results that we can share with you. We have some preliminary ones now, but I think we would like to wait until a little bit later in the year; maybe late fall, we would be able to provide that.

Senator DODD. Well, it would be helpful if we could get those earlier, because what happens is these budget cycles move around, and to the extent that you can make a case for—if they are working, obviously; if they are not, we need to know that as well—but to be

able to provide some additional resources in this area, which I think we all agree is absolutely essential. But obviously, our colleagues will ask the very simple question: "That is fine, Senator, but is it working?" And we need to know that, and if we cannot say with some degree of certainty that it is, there is going to be a reluctance to continue to fund at the levels we might like. So it is extremely important that we get some data that either confirms things are working, or tell us it is not and gives us some ideas on how we can come up with ones that do work. So it would be very helpful to get that.

I wonder if you could comment on the number of qualified grant applications for the High-Risk Youth Program, and are there sufficient funds to meet the demand.

Dr. JOHNSON. Well, the submission date is May 15 for this year. We do not know yet how many applications we will receive. For all three of our programs—the High-Risk Youth Program, as well as the Pregnant Addict and Their Infants Program, and the Community Youth Activity Program—together, we have sent out several thousand grant application packages at the request of potential grantees from around the country.

I can say when the program got started in 1986, very early, and we were not as well-known as we are today, we received 891 applications and approved, I think, somewhere in the neighborhood of 230 to 250, and had funds to support 130.

Senator DODD. And how many applications have you received so far? May 15 is not that far off.

Dr. JOHNSON. I don't know that number. I would have to submit the exact number for the record. We suspect—and this is just an estimate—something like 1,500 applications, but we have no way of knowing.

Senator DODD. That would be up in the last 2 years from the 800—

Dr. JOHNSON. Oh, yes.

Senator DODD [continuing.] So it has more than doubled.

Now tell me about funds available. How many do you think you will be able to fund out of that? Let's use the number of 1,500. It may be lower than that, but let's just use that. How many will you be able to fund with the funds available to you?

Dr. JOHNSON. For the High-Risk Youth Program, we have \$7 million available, and we think that we can fund somewhere between 30 and 35 new projects. For the Pregnant Addicts, we have about \$4.5 million available, and we think we can fund about 25. And for the Community Youth Activity Program, we have about \$10 million available, and we think we can fund somewhere in the neighborhood of around 50 or 55 programs, something in that area.

Senator DODD. So you take high-risk plus the other ones, all of them—now, when you said 1,500, you meant all applications, not just high-risk?

Dr. JOHNSON. That's right, that is all the applications.

Senator DODD. How many high-risk?

Dr. JOHNSON. High-risk youth applications, I cannot give an exact number. We will know more definitely on May 15 or around that time. But we certainly believe from just the requests that we

have received thus far that it would be in the upper hundreds in terms of numbers.

Senator DODD. Five, 6, or 7 hundred?

Dr. JOHNSON. Oh, many more than that, I would think; probably closer to 1,000.

Senator DODD. So for the three programs, you anticipate that about two-thirds of them would come under the high-risk area?

Dr. JOHNSON. Yes, that's right, Senator, because the Community Youth Activity Program has to be applied for by the States and Territories. So that would limit the number, you could reduce that number. And then what would be left would be the Pregnant Addicts Program and High-Risk Youth Program. So the High-Risk Youth would be a good percentage of the 1,500.

Senator DODD. Of the total grant applications.

Dr. JOHNSON. Yes, but that 1,500 is an estimate.

Senator DODD. And you are talking about a total, it sounded to me like, if I just roughed those numbers, maybe 100 to 150 grants that would be able to be approved based on funds available.

Dr. JOHNSON. Total—we have, I would say, about \$5 or \$7 million for this fiscal year. The next fiscal year, we would have more funds available. Of course, we would then have also—

Senator DODD. More applications, probably.

Dr. JOHNSON. That is right, a new review cycle.

Senator DODD. So you are talking roughly about 10 percent of all the applications that come in, given all three programs that we can actually fund for next year.

Dr. JOHNSON. Based upon—

Senator DODD. Just rough numbers, now.

Dr. JOHNSON [continuing.] This fiscal year.

Senator DODD. So 90 percent of the applications in drug treatment areas, we will have to turn down.

Dr. JOHNSON. Well, we have to see how many—they will be reviewed by their peers. It will be a peer review system that we will be using, and then we will see how many—

Senator DODD. But even if they were good applications, even if they were the best programs imaginable, your problem is that you can only fund, based on resources available, about 10 percent of all the applications that come in under those three areas of drug treatment programs.

Dr. JOHNSON. I repeat again, yes, for this fiscal year, we have \$7 million available for new programs—

Senator DODD. I understand the numbers you have. But my point is that even if they are great programs—I am not talking about whether they are good or bad programs; let's assume that they are good programs for the sake of discussion—my point is that of the 1,500 or so applications that come in, based on the numbers you have given me, the total number of applications that you could approve based on resource availability is somewhere in the neighborhood of 150.

Dr. JOHNSON. Total, yes, that's correct.

Senator DODD. So 90 percent of these programs, we could not fund, even if they were great programs.

Dr. JOHNSON. We could fund some few of them out of the next funding cycle after October 1.

Senator DODD. Let me turn to my colleague and I will come back for a couple other questions.

Senator COATS. Thank you for your testimony, Dr. Johnson. I wanted to just follow up a little bit.

Earlier, the chairman talked about the number of slots available nationwide. Six million people need help but there are only 250,000 slots. That presents a serious problem. I guess what I am trying to get hold of is what is the demand for these slots. Obviously, someone under a drug addiction as a very first step has to say, "I need help." And a great percentage of people out there either don't think they need help, or they are not seeking help, or they won't take that step, whether it is alcoholism or drug abuse.

Do you have any idea of what percentage of those 6 million people are actually seeking the slots?

Dr. JOHNSON. No, I don't have that definite information. It would be very difficult to come by, because——

Senator COATS. Yes, I understand that.

Dr. JOHNSON [continuing.] There are waiting lists that States have around the country, but at the same time because of the nature of addiction, to look at waiting lists as the only point in terms of judgment, it would be very hard to arrive at a definite figure.

Senator COATS. Could you expand on that?

Dr. JOHNSON. Excuse me?

Senator COATS. What do you mean, because of the nature of the addiction, the waiting lists might not be a measure of——

Dr. JOHNSON. The waiting lists are fluid in that people come on and come off on a regular basis because of addiction. When you are addicted, you want immediate help, and that is why you come in to request help, and when it is not available, a lot of times, a good number of individuals will not permit their names to be on a waiting list. They just walk away and that is it.

Senator COATS. OK. So there may be even more individuals seeking help than are on the waiting list?

Dr. JOHNSON. I am saying that could vary. They might be on the waiting list or——

Senator DODD. It could be either way.

Dr. JOHNSON. That's right. That would vary from time to time.

Let me point out, though, something that I should have said earlier, too, that these are demonstration grant programs, and that the Alcohol, Drug Abuse and Mental Health Administration also has in place the block grant that provides services. These are services demonstrations to investigate new and innovative approaches. But the service program dollars, then, necessarily would have to come out of the block grant.

Senator COATS. So a portion of your funding is not intended necessarily just to create new slots; you are trying to encourage new approaches, you are trying to seed-fund new programs and demonstrate their effectiveness and so forth.

Dr. JOHNSON. Precisely. What we attempt to do is to take from the resources that are available, as well as what we know from clinical practice, put that together and develop approaches that will address the multiple risk factors.

Now, there are a lot of variations in that because of regional differences, cultural differences and so forth, so therefore you would need a fairly good-size program to focus on all of those particular issues. But they are demonstration programs.

Senator COATS. What is the average treatment stay? What kind of time period are we talking about for treatment?

Dr. JOHNSON. It varies, I think, according to the modality of treatment. If you look at methadone maintenance treatment, we know more about adult treatment than we do about adolescent treatment, because we just don't have that much available, and not that many studies have been done. So what we know most about is opiate addiction and the treatment of opiate addiction. So that is really what I am talking about. Methadone treatment, I believe—and it varies—is somewhere between 6 months to a year—

Senator COATS. But that does not require 24-hour-a-day hospitalization.

Dr. JOHNSON. No; this is outpatient. In residential treatment, I would have to—

Senator COATS. We are talking about 250,000 slots. I assume that means 250,000 full-time, 24-hour treatment spaces.

Dr. JOHNSON. Those are spaces that are available, that's right, and more than one person might occupy that space in 1 year.

Senator COATS. Well, that's my next point. I mean, if we are talking about a 30-day treatment cycle, we can multiply the number of slots by 12. I do not know that we are talking about that.

Dr. JOHNSON. No, we're not.

Senator COATS. In some cases, it is 10 days, in some cases, it is 30 days, in some cases, it is 60 days, maybe 3 months. But my understanding is that full-time, institutional, 24-hour-a-day treatment programs are necessary at the beginning of the treatment, but then many patients can be moved to an outpatient type of program, which would then free up those slots for other people to come in.

Dr. JOHNSON. The 250,000 includes outpatient, inpatient and residential; it includes the full spectrum of the different environments of treatment. So an individual might move out of outpatient treatment into residential or vice versa—but they are still occupying one of those spaces.

Senator COATS. So then we have to address the frequency, what the turnover rate is and how long they are there, and so forth.

Dr. JOHNSON. Yes, and that varies depending upon the modality of treatment. And I believe if you could just reserve that question, some of the other witnesses that will be appearing before you, the treatment providers, can give you some ideas in terms of their own treatment programs.

Senator COATS. You also said that one of the difficulties you run into is that so much of the problem points to the need for family-based treatment, but that lack of nuclear families obviously inhibits that process considerably. Can you expand on that a little bit?

Dr. JOHNSON. Yes. What I am saying is that many of these are multiproblem families, and a lot of times that the parents, the mother and father, are not available to provide in the treatment. And what is necessary is to find who those significant others might be that would be helpful to the young person—it could be a teacher, it could be a coach, it could be other persons in the family, it

could be an aunt, it could be an uncle. So you really have to look at and identify who the significant others are that would have a positive influence on the child.

Senator COATS. But can't we link part of the drug abuse problem to the fact that someone has to look to a significant other, that the parents aren't there, there has been family turmoil or abuse or breakup or divorce or whatever—I mean, just the very fact that there has to be the question asked who is the significant other seems to me to point to part of the problem. I mean, if I were a young person, and I had to be searching out for somebody called "significant other", I think I've got problems.

Dr. JOHNSON. Yes, you do, and that is true, and that does represent reality, because many of these families—for example, one of the risk factors that we are looking at is children of substance abusers. Now, in some instances we have programs where it is a treatment program, and the adult is being treated, and we then involve the young person in our program, the High-Risk Youth Program that we are funding through OSAP, and then we are able to address the total family in that sense, and that is how we like to work it if that is possible.

But unfortunately, sometimes, for whatever reason—incarceration, or unfortunately the family member may be so invested and so addicted themselves that they are just not able.

Senator COATS. Have you done any studies, or do you have any information regarding the success of treatment where you are able to involve the nuclear family or the total family as opposed to areas where you cannot?

Dr. JOHNSON. Many of the treatment programs that you will hear from today certainly can identify some of those successes. In terms of our programs at this point in time that we fund, as I pointed out earlier, they are just in their second year. We can give you some preliminary results, but we cannot say with certainty—but we can say at this point in time, these are some preliminary results that show that this program seems to be working or moving in the right direction. I can provide that kind of information to you.

Senator COATS. OK. Just one last point. Obviously, in many of these instances, we are talking about very troubled youth, from broken families, a family structure that just is not in place to start with, and it is obviously difficult to pull all that back together in a treatment-type program. Others come in where the family is together, and you can incorporate and involve them in the process.

I guess one of the questions I am trying to get at is recognizing the victims here and the need for treatment, but how do we move to the prevention side? What things can we do that will allow us to slow down the rate, to prevent these things from happening in the first place? That is not necessarily where your program is structured—or perhaps it is—do some of your grants go toward the prevention side?

Dr. JOHNSON. The central thrust of OSAP's program is in the prevention area, but because so many of the high-risk youth are already drug-involved, then we necessarily have to look at early intervention and treatment as well. But certainly, prevention is a major concern and a major priority of the organization, and many

of our programs certainly, then, provide prevention services. In the multiproblem families that we just discussed, for example, parenting is certainly a major issue there. And if we are talking about, for example, a comprehensive program that has a treatment program, but also a prevention program, then part of that support will be in helping to develop parental skills in that particular family, family practices, family management, as well as helping them learn how to work with the other systems in the community, whether it is the school system or the health system. Many of them are involved with the juvenile justice system, helping them work through that, and also developing a case management approach. So it is a coordinated approach so that so many agencies are not pulling the young person or the family in too many different directions.

Senator COATS. Thank you very much.

Senator DODD. Senator Adams.

Senator ADAMS. Thank you very much, Mr. Chairman.

Dr. JOHNSON, it is a pleasure to see you.

I spent the last week in Seattle, and a great part of that time in the treatment centers and in some of the use of the block grant money that has been used for both substance and alcohol abuse treatment.

My first question is not at all a hostile one, it is for information, because I am concerned about it. Have you received any appropriated money out of the drug bill money, the so-called \$2.8 billion that was passed last year?

Dr. JOHNSON. Yes. A supplemental bill in fact supported OSAP quite a bit. Our budget was only \$34 million at the time, and now—

Senator ADAMS. So you did receive—

Dr. JOHNSON. Yes.

Senator ADAMS. I am pleased to hear that, because one of the criticisms that I am hearing, Mr. Chairman—and I am asking for information, because I simply don't know—what happened to the difference between the two-point-some billion dollars that we have supposedly spent on this and the fact that less than \$1 billion has actually been spent. If your program receives some, I am going to be asking other witnesses the same question.

Dr. JOHNSON. It was \$34 million, so we must have received somewhere close to around \$35 million.

Senator ADAMS. All right. My second question is this. In visiting these treatment centers in Seattle—and I intend to do the same in the District here when I get a chance to do so—they indicated to me that with children and young adults that have a drug problem, particularly the cocaine or crack problem, that as opposed to alcohol or some of the others, they get a relatively quick physical detoxification, but they get almost no results with the psychological craving—in other words, they cycle immediately back into where they were before, and that the problem is a diversion of lifestyle. The reason I mentioned the detoxification—they described the differences between the heroin detoxification and the alcohol detoxification and the detoxification for drugs like crack cocaine—the only reason I mention that you get a different effect there is that they say that if you don't get a complete change in where the person is

returned, the craving is such that they almost immediately cycle back in. Is that correct? Is that your experience?

Dr. JOHNSON. That is correct, and you can have that also with the opiates as well, in terms of a continued craving for the drug. But it is particularly true for drugs like crack cocaine; because of the physiological effect of the drug on the body, it creates intense craving, particularly crack cocaine because of the way that it is administered, that they are able to get so much of it into their system and also the fact that it is more purified, the purity rate is much higher, and you have a more dramatic euphoria, and it creates a psychological effect.

Senator ADAMS. Mr. Chairman, I will not ask any more questions, because I know you have a number of witnesses here, but I did want to indicate that we will, before one or the other appropriations subcommittees, continue this.

The particular problem we are trying to address is that when we have a situation, we are not ordinarily able to hold a lot of the juveniles that are involved in the crack and the cocaine and so on, because their physical appearance and their physical treatment does not warrant, in a standard detoxification center, and long holding period, and if we put them right back out on the streets, which we are doing, we cannot ever control the streets.

So that was the reason for my question. I will withhold my others. I would like to submit one or two in writing to the witness if I might.

Senator DODD. Absolutely.

Thank you very much, Senator Adams.

Senator ADAMS. Thank you.

Senator DODD. I just want to come back if I can just briefly, Dr. Johnson, on the number of slots available and that potential pool—I hope I made that clear—we talked about the 6 million-plus. Just so I am clear, that number reflects people in our estimation who need treatment. That is not just users. We know the number of users is much higher than that. We are talking about people who are guesstimates or estimates are that that is the size of the population, the growing population of people who would fall into the category who need treatment of one kind or another.

Dr. JOHNSON. They need treatment. All of those included in that number may not have admitted themselves to a treatment program.

Senator DODD. That is my next question. I am not clear in my own mind—is that an estimation of the population of people who would—

Dr. JOHNSON. That is an estimate in terms of the number of people who require treatment. We would have to find ways of bringing them into treatment.

Senator DODD. All right, but what kind of treatment are we talking about?

Dr. JOHNSON. We are talking about treatment across-the-board. If you are talking about, for example, IV—

Senator DODD. Well, would it be inpatient treatment we are talking about, that population?

Dr. JOHNSON. No.

Senator DODD. Not necessarily.

Dr. JOHNSON. Not necessarily, no, because a good percentage—in fact, I think, the overall percentage—is in outpatient treatment. We are talking about IV drug users, we are talking about those who are abusing cocaine and other drugs. We are talking about the full spectrum of drug users in terms of those who are in need of treatment, but we would have to find innovative ways, again, to bring them into treatment.

Senator DODD. But you are excluding, obviously, a significant number of people who are using drugs.

Dr. JOHNSON. No. Those numbers that we are talking about are drug users.

Senator DODD. But my Lord, the number of estimates of the number of cocaine users—someone told me it is around 20 million.

Dr. JOHNSON. Yes, but everyone who is using would not require the type of treatment that would be afforded by the treatment slots.

Senator DODD. I understand.

Dr. JOHNSON. We estimate there are somewhere around 5 to 6 million—this is old data, coming from the 1985 household survey—cocaine users in the country. But those who would require the actual treatment, whether it be residential, outpatient and so forth, would not be the full 6 million. We estimate there are around, I believe, 1.2 million IV drug users in the country. Now, I would say that they are in need of treatment if they are IV drug users, but we don't know how many would actually come in for treatment if treatment were available. We believe that a good percentage of them would come in for treatment as witnessed by the waiting lists that we have formed around the country, although that is a very fluid process, as I mentioned earlier. It is still probably the best indicator that we have available in terms of the demand for treatment.

Senator DODD. What about someone who is using marijuana or hashish? Do you put them into the category of someone who ought to get some treatment?

Dr. JOHNSON. If they are chronic marijuana users, yes—they need some type of intervention if they are marijuana users.

Senator DODD. What is our population number in that category?

Dr. JOHNSON. I think we estimate somewhere in the neighborhood of about 18 million marijuana users.

Senator DODD. I may be confusing that number when I am trying to recall off the top of my head the percentages of users in the various categories.

So for purposes of clarity, I think there was some confusion—it sounded like we had identified a specific population that clearly need treatment and an additional part of the population that are users—the numbers get thrown around—

Dr. JOHNSON. Yes. Let me say this, that in terms of users, I can give you the estimates in terms of the most abused drugs. For the opiates, we estimate there are 500,000 opiate users in the country. We estimate that there are 18 million marijuana users, and we estimate that there are close to 6 million cocaine users. Now, those are the most abused of the illicit drugs.

Senator DODD. Those are regular users.

Dr. JOHNSON. Those are regular users, right—well, you even have to qualify that. Those are users just in the general population. Daily users, which you are talking about, I do not have that number right off the top—

Senator DODD. But obviously, less than that.

Dr. JOHNSON. Yes, but it is a good percentage of those. Your point, though, I think the point that you are making, is that there are many, many more users—we believe that there are only about 10 percent of the people in treatment that should be in there—that we are not fully meeting the treatment need, and that means both Federal, State, private and so forth, that if you add all of those together, we certainly do not have the slots available to treat those people. I think that is the bottom line.

Senator DODD. We talked about the Federal funding, and I think you pointed out correctly that a lot of these are demonstration grants. There are block grants. What is the total number on the block grants?

Dr. JOHNSON. The total number for the block grants—and that includes alcohol and other drugs—is around \$806 million. That is the number in terms of block grants; that is Federal support from the Department of Health and Human Services.

Senator DODD. For block grants for total substance abuse treatment programs?

Dr. JOHNSON. That is right—I am sorry—that is Alcohol, Drug Abuse and Mental Health Services block grant is \$806 million.

Senator DODD. Is Federal funding available to maintain these programs after their initial cycle? I am going back now to some of the demonstration programs—that is how you described them, the ones that you talked about.

Dr. JOHNSON. Yes, those that prove effective, whether or not they could then be continued.

Senator DODD. Right.

Dr. JOHNSON. I think that is an issue and a problem, because if you do not have sufficient ones for the people already coming into treatment, then I think there would be some difficulty in continuation of some of these programs for some of the States. We certainly are working very closely with the State agencies, and we strongly encourage the people that we support, because we usually only support them up to 3 years, to look at other sources of funds if they have proven effective strategies based upon a demonstration period.

Senator DODD. So at this particular juncture the conclusion is there does not appear to be the non Federal resource capacity to sustain some of these programs if in fact they turn out to be worthwhile.

Dr. JOHNSON. Well, if they indeed have proven that they have effective strategies, and now it can just become a service program, then we would have to look to the block grant for continuation, or State or other types of funding for these programs.

Senator DODD. But as far as non Federal funding, there doesn't necessarily seem to be a great deal of resource capacity out there, is that what you are saying?

Dr. JOHNSON. I don't believe so, with the current status.

Senator DODD. We have some additional questions—Dan, I don't know if you want to follow up with any additional ones now—

Senator COATS. No. Thank you.

Senator DODD [continuing.] But we will submit some questions to you, Dr. Johnson, if we could. We are very interested in following this. I apologize for these numbers. Too often what happens is you get some hyperbole on the numbers, and you want to make sure you are dealing with the right ones, because as we try to be of assistance in providing additional funds for these programs, we want to make sure we know exactly what we are talking about here.

Dr. JOHNSON. And I am very pleased that you are doing that. We were focusing at one point on adolescents, and then when you brought in the other numbers, we were talking about adult treatment. And we do have some very good figures that we do have some degree of confidence in at ADAMHA, and we would be very happy to submit those to you.

Senator DODD. I would like to get those as well, and I didn't want to get even more confusing, but in terms of breaking down these numbers even further—in particular, we talked about percentage increases at the outset—clearly, there is a pattern, it seems, of the numbers going up even though the population is decreasing, and we want to focus on that.

Dr. JOHNSON. Yes. The point is that these programs, because so much is now known and needed to address the issues of adolescent treatment, prevention and rehabilitation, because as I pointed out, these programs in the treatment area really came from adult treatment.

Senator DODD. Let me ask you this—and you don't have to go into it in great length—but is there a profile, in your view, of the youth at risk that comes across, the prototypic youth at risk, and what appear to be the predisposing personality traits, if there are any, that we ought to be looking for as we see these children move from infancy or early childhood into adolescence, that would indicate that there is a greater risk or a higher risk that those children are likely to fall into the substance abuse category?

Dr. JOHNSON. In terms of the point that you made in terms of biological vulnerabilities, we don't have a lot of data on that at this point in time. The data that we have clearly focus on the adult male alcoholic and the young male son. Research has really shown a clear link there. So we have confidence that there is a genetic link between those two, but in terms of the other drugs, and in terms of young females—

Senator DODD. Behavioral traits?

Dr. JOHNSON [continuing.] Yes, we don't have that. However, when you look at some of the other kinds of dimensions, particularly those, for example, that are identified in our legislation in terms of profiles and vulnerabilities, children of drug users, because there you have role modeling as well as the parental deficits that are operating in a particular family there, so clearly those young people are at risk.

We have youth who experience problems in school as being another group; disadvantaged youth, for any number of different reasons; youth who have already begun delinquent acts and have been caught up in the juvenile justice system; youth who have emotional

problems, particularly suicide in youth. These are factors that we find correlate with adolescent drug use. We still need to know more information about, clearly, what the actual pathways are, which comes first, but we know that they are correlated.

Youth who are delinquent, youth who have dropped out of school, we certainly know that that is a major factor. And then a whole host of family environmental factors—some resources have looked at issues like self-esteem and those kinds of issues as well.

So there are a whole multitude of kinds of psychosocial, we call them, factors that place youth for special vulnerability to drug use.

Senator DODD. Again, we will have some additional questions for you, and that will help us to formulate this policy.

We thank you for being here with us this morning.

Dr. JOHNSON. Thank you for having me.

Senator DODD. Senator Adams, does that satisfy you?

Senator ADAMS. Yes. I have no further questions, Mr. Chairman.

Senator DODD. Thank you very much.

Our next panel consists of Dr. Mitchell Rosenthal, and joining him will be Dr. Robert Lewis. Dr. Rosenthal is the director and founder of the Phoenix House Drug Rehabilitation Program in New York and in Los Angeles, and he will have with him two adolescent clients from Phoenix House.

Dr. Robert Lewis is a professor at Purdue University in Indiana, and possibly my colleague from Indiana might like to introduce Dr. Lewis, if you would care to.

Senator COATS. I would be happy to, Mr. Chairman.

Dr. Lewis has done some distinguished work in the area of drug treatment. He has been a professor in the Department of Child Development and Family Studies at Purdue University since 1981, and his programmatic research on families and drug addiction has been funded for the last 7 out of 10 years by the National Institute on Drug Abuse. He has a whole list of publications and efforts that he has been involved in, and I think he brings a very important perspective on how we can most effectively treat, in many instances, drug addiction. He is involved in clinical studies and practical studies as part of his efforts and is just concluding a very important 5 years of research in the whole area of family therapy.

So I am very pleased that he is able to testify before the committee, and I think he has a great deal to offer the committee as we evaluate this subject.

Thank you, Dr. Lewis, for the time and efforts that you have made in this area and for coming out to testify before us today.

Senator DODD. Thank you, Dr. Lewis for being with us.

I would be remiss if I did not point out we wish Phoenix House a "Happy Birthday" for its 22 years. So we really have some experience in front of us here.

Lisa and Michael, we are pleased that both of you are here with us today, and we thank you for coming. It is not an easy thing to step forward and talk about personal difficulties or family difficulties, but we want you both to know that by doing so, you help us tremendously, and just by being here you may help some other people. We talk numbers and statistics with the professionals, but you can talk about it in terms that other people really can understand. So I want you to know I personally appreciate very much

your willingness to come to Washington and to come forward and talk about your experiences. It is very, very helpful.

Dr. Rosenthal, we thank you again for being a part of this, and we are anxious to hear your remarks.

I would tell both my colleagues that we are going to have some votes beginning at 11:30 a.m., two of them back-to-back. We will try and get through your testimony, and then we will take a break and come back for the questioning, if we can.

Dr. Rosenthal.

STATEMENTS OF DR. MITCHELL ROSENTHAL, DIRECTOR AND FOUNDER, PHOENIX HOUSE DRUG REHABILITATION PROGRAMS, NEW YORK, NY AND LOS ANGELES, CA; LISA, ADOLESCENT CLIENT, PHOENIX HOUSE, NEW YORK; MICHAEL, ADOLESCENT CLIENT, PHOENIX HOUSE, NEW YORK; AND DR. ROBERT LEWIS, PROFESSOR, PURDUE UNIVERSITY, WEST LAFAYETTE, IN

Dr. ROSENTHAL. Thank you, Senator Dodd, Senator Coats, and Senator Adams.

We are delighted to be here today. Phoenix House did begin 22 years ago today, and it is our birthday, and we are happy to celebrate it with you.

I have some prepared testimony, but I think that I will just leave that testimony with you and let it become part of the record, rather than try and go through it and hit some of the highlights, and I hope that we can spend more of the time with questions and discussion.

I think there is a widespread belief that what we need now are new answers and new cures and new ways of dealing with drug abuse, specifically youthful drug abuse, and crack cocaine use. The fact is that drug abuse is a mystery, I think, that we solved more than 20 years ago. We do know the answer, and we can cure it, and we do cure it quite regularly and quite predictably.

We have the methods. What we lack are the means. I think you were trying to underscore that before, Senator Dodd, in your questioning. We have the knowledge, and we do not have the resources, and we do not have the societal commitment to confront and overcome youthful drug abuse.

It strikes me as very strange that this is true when you consider that drug abuse has been, since the early Seventies, the greatest single threat to the health and well-being of young Americans.

It is hard to get a clear count on the numbers, and we have an awful lot of conflicting data. If you look at the NIDA survey, the annual high school survey, it is really in some ways encouraging. Over a decade, you can see a decline in drug use with adolescents that are in school. You go back 10 years ago to 1979, and we had a high of 12 percent of high school seniors who were getting stoned or drunk every single day on marijuana. Last year when the survey was done, that number was down to 3 percent. That is a very considerable improvement.

Cocaine use among seniors fell for the first time, and this year, crack use declined in this same survey. In a New York household

survey, we don't see any such decline at all, and the numbers remain constantly high over the past 5 years.

With all of this improvement, of the people in school, half of the class of 1988 will have used illicit drugs at some time in their young lives. And the dark side of all of this is what the high school survey does not show and cannot show—that is the drug use among adolescents who never get as far as the 12th grade. Here I think among the dropouts, mostly in our major cities, is where we are having an increasing problem of proportions that we are just beginning to get a glimpse of. We do not have good data on crack consumption. We have a lot of data on crack and crime. I think some of the figures you showed earlier begin to show that. If you take a quick glimpse at the figures, between 1983 and 1984, we have figures that rose 68 percent in New York; 61 percent here in DC, 55 percent—

Senator DODD. That is the percentage increase in what, Dr. Rosenthal?

Dr. ROSENTHAL. In drug-related arrests.

Senator DODD. And overall, that is adults as well as—

Dr. ROSENTHAL. Yes. This is adults and adolescents.

We had a 61 percent increase in the District here, 55 percent in Los Angeles, and 147 percent in Miami. Smaller cities have also been affected. Drug arrests were up 124 percent in Buffalo, 125 percent in San Antonio, 434 percent in Sacramento.

More arrests are involving adolescents. The number of juveniles held on drug or alcohol charges rose 50 percent from 1985 to 1987. In New York, the number of 13- and 14-year-olds arrested for possession of cocaine or heroin doubled between 1986 and 1987, and it doubled again between 1987 and 1988.

One very important thing I think we ought to understand about crack, as potent as it is and as rapidly addicting—and it certainly is the most rapidly addicting drug pharmacologically that we know—it differs from other drugs in degree and not in kind. Kids use crack for the same reason that they use other drugs. They break away, they stay free, they get well in the same way that they do from other drugs.

The point of this is to say that we do not need special programs or special treatment for crack addicts. We do not, for example, as one of your distinguished colleagues recently wrote in the *New York Times*, need a methadone clone to deal with crack. Even if such a substance were biochemically possible, it might be useful, but it is hardly essential.

Not one of the crack-addicted kids that we treat at Phoenix House require chemical help to overcome dependency, and you will hear more about that. And I think notions like the methadone clone proposal simply demonstrate a widespread failure to recognize the basic nature of treatment and the difference between detoxification and cure.

Treatment does not end when withdrawal ceases. That is when treatment begins. I think that is what Phoenix House and many other drug-free programs today around the country have demonstrated. We have a lot of programs in this country—Daytop Village in New York, Vitam in Connecticut, Marathon House in New Eng-

land, Gateway in Chicago, Amity in Tucson and some 250 other programs around the country that are doing this course of work.

We have done a lot of long-term research on the populations that we treat, looking at people who left with our blessing and many who left without our blessing, who left treatment prematurely. We have looked at them 3 years, 5 years, and even 7 years later, looking at how they are doing at work, in school, have they been involved in any way with the criminal justice system, again, and have they remained drug-free.

Our research shows that those who stay the full course of treatment will be 90 percent successful. Those who stay for 12 months, which is not the desired optimal time, 70 percent of them 5 years later will be drug-free, working, in school full-time, and not involved with the criminal justice system.

Just a word or two about treatment. Treatment depends not just on therapy groups but on an overall support structure and behavioral demands of the treatment community. And when we say a "treatment community", we are generally talking about a facility in which 75 to 200 youngsters may be involved. The process that goes on allows residents to overcome emotional problems, the inner problems in attitudes and values that underlie not only drug abuse, but all kinds of anti-social and self-destructive behavior.

We have developed in the last 7 years something that we call the "Academy model". The first and largest of these is the Phoenix Academy in Westchester, New York. This is a 250-student residential high school for youngsters in treatment. Three of our California adolescent programs also follow the Academy model, and this year we plan to open a New Jersey Academy and an academy at the Nancy Reagan Center we are developing in Los Angeles.

These academies give kids a chance not only to break free from drugs, but to make up for the years they lost to drugs as well and to catch up academically. Our students live in a 24-hour-a-day, highly-structured environment, and it is a very demanding system. Within this community, behavior is monitored, and positive performance is encouraged not only by teachers but by senior residents. Peer pressure here is all positive, and the goal is a total behavioral change and a change in attitudes and values.

The academies are really just one of the services that Phoenix House provides because it takes, really, a continuum of services, as Dr. Johnson was pointing out, to provide the total array of work that is necessary for any particular neighborhood or community.

It is important to point out that education and prevention are not going to succeed unless we have developed ways to deal with the kids who are already using drugs. Unless there is a road back for these kids, we are not going to succeed with the others.

We see that long-term residential treatment—and by that, we mean treatment of 12 to 18 months—is the base upon which we build our system. It is really the bottom-line capacity. If you don't have that capability, no response to youthful drug abuse can be really effective. This is the capability that most communities lack. No service is more necessary or harder to find than affordable, long-term residential treatment for adolescents.

We have just opened such a unit in our Westchester Academy to care for New Jersey youngsters because there is no such treatment

now available in the State of New Jersey. In all of Los Angeles, there are only 93 beds for kids who need this kind of care. In all of New York State, which probably is, along with the Federal block grants, putting more into drug abuse services than any other State in America, there are less than 500 such beds for kids who need these services.

A couple of words on the barriers to access. I think No. 1 is resources. I think that we simply have not seen the funds. We have not seen the funds from the Federal Government, we have not seen the funds from the States, we have not seen the funds from the counties or from our cities.

The special funds that were appropriated in 1986 by the Congress were short-term grants, and additional funds approved in 1988 have generally been targeted for the treatment of IV drug users, and to those who are on waiting lists. This is money that is desperately needed, but it does not provide additional capacity for adolescents.

There is also little support for drug abuse treatment from the private sector. I think Phoenix House is something of an exception to this. We get considerable amounts of support from the private sector. But even in the instance of Phoenix House, this amounts to less than 20 percent of our overall budget.

It has been hard to overcome the stereotype of kids that tends to inspire more fear and anger than sympathy. So paradoxically, there is a very small donor base given the vast impact that this illness has had on American families.

Now, most American families, most middle-class families, count on insurance coverage, and drug abuse treatment that most kids get now is dictated more by insurance benefits than by patient needs. This is seen in the very short-term, very high-cost treatment that generally runs 30 to 45 days, and for most kids who need residential care, 30 to 45 days is barely enough.

Insurance requirements and limitations have——

Senator DODD. What are you talking about in terms of cost? I cited \$5,000 a year——

Dr. ROSENTHAL. I think the \$5,000 a year figure is very misleading, because that is a Federal average. If you look at a youngster in treatment at Phoenix House in a year, that cost is going to be more like \$18,000 a year.

Senator DODD. So you think that figure is very low?

Dr. ROSENTHAL. I think your figure is low. You have a figure of \$5,000, of treatment costing \$5,000 a year, which is averaging in methadone slot costs, outpatient slot costs, and all of treatment, and not looking at residential treatment.

I think the point here is that for a family that has a youngster, 13, 14, 15, 16, or 17 years old, a kid who is out of control, a kid who is in trouble with drugs, dropping out of school or barely making it in school, a kid who cannot be handled in an outpatient setting and who needs residential care, there are practically no resources available. The family that has insurance is going to see that youngster in a 28- to 30-day program. It will zap the insurance dollars in one fell swoop, generally taking anywhere from \$500 to \$1,000 a day to cover those costs, and then nothing is left to handle the kid who has got that problem.

Senator DODD. So obviously, the 37 million in this country who are either under-insured or have no insurance at all are just out of the picture entirely.

Dr. ROSENTHAL. That is right.

Senator DODD. I am sorry. I did not mean to interrupt you. Go right ahead.

Dr. ROSENTHAL. I just wanted to close on another unhappy note, which is the axiomatic community response that we see now, called "NIMBY"—"not in my back yard"—which is causing us an extraordinary amount of grief. Whether we are opening a program in rural San Diego, in Westchester, New York, or in the City of Los Angeles, the response is the same: Terrific program, but please do it somewhere else.

Senator DODD. Thank you.

[The prepared statement of Dr. Rosenthal follows:]

PREPARED STATEMENT OF DR. MITCHELL S. ROSENTHAL

My name is Mitchell S. Rosenthal. I'm a psychiatrist and the president of Phoenix House ... which, incidentally, began treating drug abusers just 22 years ago today.

We've changed a lot since then. From a New York City treatment program ... we've grown to become the nation's largest non-profit drug abuse services agency. We provide a full spectrum of services ... operate six treatment centers in the New York metropolitan area ... and four in California.

Phoenix House was a pioneer in the development of drug-free treatment for drug abusers ... and we have created model treatment programs for adolescents. We believe we understand how to deal with drug abuse ... both drug abuse of the individual ... and drug abuse within our society. And so, we are somewhat mystified and disturbed by many currently proposed "solutions" to America's drug problems.

There seems a widespread belief that what we need are new answers ... new cures ... new ways of dealing with drug abuse. But that is not the case. Drug abuse is a mystery we solved more than 20 years. We KNOW the answer. We can cure it ... and we do cure it ... regularly and predictably.

We have the methods ... what we lack are the means.

We have the knowledge. But we do not have the resources ... and we do not have the societal commitment ... to confront and overcome youthful drug abuse.

And that strikes me as truly strange ... when you consider that drug abuse has been ... since the early Seventies ... the single greatest threat to the health and well-being of young Americans.

This is plainly true today ... although it's hard to get an accurate fix on just how much adolescent drug abuse we now have. If we look at NIDA's annual survey of high school seniors, we can see gradual improvement over the past decade ... a slow but steady decline in overall drug use ... and a highly significant falloff in daily use of marijuana. Two years ago, cocaine use among seniors fell for the first time. This past year, crack use declined--at least among kids who made it into twelfth grade.

But improvement is relative. In spite of greater awareness of drug dangers ... and significant increases in disapproval of drug use ... more than half the class of 1988 use illicit drugs at some time in their young lives. Two out of five were using illicit drugs during their senior year ... and one out of five was using a drug more potent than marijuana.

And that's the bright side of youthful drug abuse. The dark side is what the high school survey doesn't show--and can't show. That's drug use among adolescents who never get as far as twelfth grade. And it is here, among dropouts--and mostly in our major cities--that today's crack epidemic is raging.

We don't have data on crack consumption. But we do have data on crack and crime. Since the crack crisis began, drug-related arrests have soared. Between 1983 and 1984, they rose 68 percent in New York, 61 percent here in D.C., 55 percent in Los Angeles, and 147 percent in Miami. Smaller cities have been affected too. Drug arrests were up 124 percent in Buffalo, 125 percent in San Antonio, and 434 percent in Sacramento.

And more arrests involved adolescents. The number of juveniles held on drug or alcohol charges rose 50 percent from 1985 to 1987. In New York, the number of 13-and-14-year-olds arrested for sale or possession of cocaine or heroin doubled between 1986 and 1987 ... and doubled again between 1987 and 1988.

But let's understand something important about crack. It IS a potent drug ... the most rapidly addicting we've seen. But it differs from other drugs only in degree ... not in kind. Kids use crack for the same reason they use other drugs. And kids break free--and stay free--from crack ... in just the same way they break free--and stay free--from other drugs.

We don't need special programs ... or a special treatment ... for crack addicts. We don't ... for example ... need a "methodone clone" to deal with crack ... even were such a substitute substance biochemically possible. It might be useful but it far from essential. None of the crack-addicted youngsters we treat at Phoenix House require chemical help to overcome dependency.

Indeed, notions like the methodone clone proposal simply demonstrate a widespread failure to recognize the basic nature of treatment ... and the difference between detoxification and cure.

True treatment does not END when withdrawal ceases .. that's when it BEGINS.

This is what Phoenix House and other drug-free programs first demonstrated more than 20 years ago. It is what subsequent studies have shown to be predictably effective. Nearly 90 percent of Phoenix House residents ... who stay for the full course of treatment ... are successful. And we find them remaining drug free and leading useful, productive lives for as long as our long-term outcome studies have followed them.

Our program graduates are not unique. Other drug-free programs have similar results ... Daytop Village in New York ... Marathon House in New England ... Gateway in Chicago ... Amity in Tucson ... or any of the 250 such programs throughout the country.

These programs employ the same self-help model that Phoenix House does. Based -- in part -- on principles introduced by Alcoholics Anonymous, this approach recognizes that drug abusers cannot be passive recipients of medication or therapy. They must be active participants in their own cure.

Treatment depends not only on therapy groups ... but upon the structure, support, and behavioral demands of the treatment community as well. The process allows residents to confront and overcome emotional problems, attitudes and values that underlie ... not only drug abuse ... but all kinds of antisocial and self-destructive behavior.

The self-help model has proven to be infinitely adaptable ... effective for all drug abusers ... and abusers of all drugs. It has been adapted to outpatient treatment as well as residential care. And, at Phoenix House, we have devoted a growing share of resources to developing drug-free treatment and intervention programs for adolescents.

Youngsters have special needs ... and special problems. Many who enter treatment today come from disruptive families and abusive homes. More than a few have no idea of societal norms.

To treat adolescents, we have developed treatment centers based on ... what we call ... the academy model. The first and largest of these is Phoenix Academy at Shrub Oak, New York ... a 250-student residential high school for youngsters in treatment. Three of our California adolescent programs also follow the academy model. And this year, we plan to open a New Jersey Academy and an academy at the Nancy Reagan Center we are developing in Los Angeles.

These academies give kids a chance not only to break free from drugs ... but to make up the years they lost to drugs as well. They can catch up academically and recapture opportunities for college and for careers.

Academy students live--24 hours a day--in a highly structured environment ... a family-like community that demands and rewards adherence to its expectations ... and is able to impose sanctions for the failure to meet those expectations.

Within this community, behavior is monitored and positive performance encouraged and supported ... not only for teachers and counselors ... but by senior residents. Here, peer pressure is all positive. And the goal is change ... behavioral change ... and change in attitudes and values.

The Academy works to remedy all kinds of deficits ... social and vocational ... as well as academic. All students have work assignments, and the school provides job training and placement for those not college-bound. Family participation is a requirement, including parent education ... parent groups and family counseling and therapy.

But the academies are only one of the youth services that Phoenix House provides ... for it takes more than treatment to deal with youthful drug abuse.

Services for youth, however, are all mutually supporting.

Drug education and prevention, for example, are unlikely to succeed unless there are ways to deal with youngsters who are ALREADY using drugs ... and unless there is "a road back" for youngsters who are already drug impaired.

That's why a good many drug abuse professionals talk about a "continuum of services" that includes drug education and other prevention efforts, in-school and after-school intervention programs, and both out-patient and residential treatment.

At Phoenix House, we provide the full range of these services. But long-term residential treatment is the base upon which our system is built ... the bottom-line capability.

Without that capability ... no response to youthful drug abuse can be truly effective. And it is a capability most communities lack. No service is more necessary or harder to find than affordable long-term residential treatment for adolescents.

We've just opened a unit at the Shrub Oak Academy to care for New Jersey youngsters ... because no such treatment is now available in that state. In Los Angeles ... only 93 youngsters get this kind of care.

What are the barriers to access?

Resources, for one. Demand for treatment has dramatically increased in recent years. But government support for treatment has changed hardly at all. To be sure, extra funds have been authorized. But the special funds appropriated in 1986 provided only short-term grants ... not the long-term commitments needed to open, staff, and equip residential treatment units. And additional funds approved in 1988 have been generally targeted for the treatment of IV drug users ... to cut THOSE waiting lists ... and not to provide additional capacity for adolescents.

There is little support for drug abuse treatment from the private sector ... from corporations, foundations, and individual contributors. Phoenix House is something of an exception to the rule. We get a considerable amount of private sector support. But treatment for adolescent drug abusers is not easy to sell. It's hard to overcome the stereotype of these youngsters that tends to inspire more fear and anger than sympathy.

Some families can afford the client fees for long-term residential care. But most middle-class families count on insurance coverage. As a result, the drug abuse treatment most youngsters now receive ... is dictated more by insurance benefits than by patient need. It is generally short term and high cost ... 30-to-45 days of in-patient hospital care.

For most youngsters who NEED residential care ... 30-to-45 days are rarely enough. Insurance requirements and limitations have made profit centers out of thousands of underutilized hospital beds. But they have done little to help most youngsters get the treatment they need.

But not all the barriers to access are financial. There is the question of commitment as well as resources ... societal commitment ... and community commitment.

Services can function only as part of a consistent and coherent response to youthful drug abuse. Communities must be able to make a "no drugs" demand. Schools must be able to identify drug-troubled youngster ... and have effective programs to which to refer them.

But few communities today seem willing to respond aggressively ... to spend the money for services ... or take the hard line. Indeed, many communities will fight to keep drug abuse services OUT.

Treatment programs now must overcome strong community opposition in order to open. The negative response is almost automatic ... we call it the NIMBY syndrome. "Sure" folks say, "there should be drug treatment ... only Not In My Backyard."

So, let me say, in closing that ... while there is much to learn about drug abuse ... there is no central mystery to solve ... no impediment to a solution. We know what to do. We know how to do it. All we need are the resources and the commitment.

Thank you.

Senator DODD. We will recess for a few minutes—I apologize to you, Dr. Lewis, we cannot control the bells over here—and Lisa and Michael, we will come back for your statements as well.

The subcommittee will stand in recess. It will be about 20 minutes by the time we cast two votes and get back over here. So you can take a break.

[Short recess.]

Senator DODD. The subcommittee will come to order.

My apologies again to our witnesses, but unfortunately we do not control the time out here. Again, Dr. Rosenthal, we thank you for your testimony.

Before getting to Dr. Lewis, let's ask Lisa and Michael—I know you have some prepared remarks—why don't you share your thoughts with us? Again, our thanks for being here.

Lisa, do you want to lead off?

LISA. OK. My name is Lisa. I am 21 years old and a student at Phoenix Academy.

Some children turn to drugs because they aren't loved. That was not the case with me. I was raised an only child by my mother and father. They were divorced, but the three of us spent a lot of time together. They always showed me a lot of love and made me feel special. I was special.

When I was 12, I started classes at the Dance Theater of Harlem. One day, I decided to play hooky and hang out with a friend. She introduced me to some of her friends. One of them was Enrique. I later found out he was selling drugs. What I liked the most was he was 18 years old, and he liked me. At the time, I was 13.

I started playing hooky every day to be with him. Then, after 4 months, I became pregnant. My mother was devastated. My father tried to talk to me, but I didn't want to hear anything. I thought I was in love.

My family wanted me to get an abortion. I refused and moved to a maternity residence. I stayed there until I had my son, Anthony. At first we moved in with Enrique and his family. When he began to mistreat me, I took Anthony home to my mother's.

I hated myself, and I thought my parents hated me, too. I started hanging out with Enrique again. I stopped going to school and started using drugs—marijuana and cocaine. I had never used drugs before. Soon I was using drugs every day. Then Enrique introduced me to crack.

When I started using crack, I began stealing from my mother. She got fed up and told me to either get some help or leave her house, so I left. I was living on the streets and getting high with anybody. Some days, I did not eat or sleep. I did not want food; all I wanted was crack. I would walk the streets—dirty, tired and hungry, crying, thinking how I had ruined my life.

Finally, I went home to my mother and told her I needed help. The next day, she took me to Phoenix House. I enter Phoenix Academy in July 1987.

In the first 3 months of my treatment, I was in total shock. There were so many rules. I could not smoke without asking. I could not put my hands in my pocket. I even had to get permission to go to the bathroom. And I did not want to hear about my negative attitude.

When I finally called my mother, the first thing I said was, "Could I come home?" She told me I had to stick it out. I felt so alone. I couldn't go home, and I didn't want to stay at the Academy.

I got tired of being hassled about my behavior, until one day I realized I wanted to change, but I did not know how, and I was afraid to ask for help. I did not think I could change. That is when I got serious about treatment and learned that the staff and my friends really cared about me. They showed me that I could be a better person, and they would help me.

So, after a lot of pain and tears, I have changed. I am now 21 and have been at Phoenix Academy for 22 months. I have grown up to be a responsible young woman with plans and goals. I will have my high school diploma in the fall and plan to go on to college.

I am grateful to Phoenix House for giving me a second chance. My old dreams were destroyed, but I have a new one: To become a responsible mother, to make a career for myself and a new life, and most of all, to stay drug-free.

I want to thank my mother for making me get the help I needed, and I want to thank all of you for making sure Phoenix House was there for me.

Thank you.

Senator Dodd. Thank you, Lisa, very much. We appreciate it.

LISA. You are welcome.

[The prepared statement of Lisa follows:]

PREPARED STATEMENT OF LISA

My name is Lisa. I am 21 years old and a student at Phoenix Academy.

Some children turn to drugs because they aren't loved. That wasn't the case for me. I was raised an only child by my mother and father in East Harlem. They were divorced, but the three of us spent a lot of time together. They always showed me a lot of love and made me feel real special. I was special.

I passed the test for the Hunter College elementary school, and I did well there. I loved school and planned to be a doctor. My parents were proud of me.

When I was 12, I started classes at the Dance Theater of Harlem. One day I decided to play hooky, and hang out with a girlfriend. She introduced me to some of her friends. One of them was Enrique.

I thought he was a real big shot. He wore expensive clothes, designer jeans and lots of jewelry. I later found out he was selling drugs. What I liked the most was he was 18 years old and he liked me. At the time, I was 13.

I started playing hockey every day to be with him. Then after four months, I became pregnant. My mother was devastated. My father tried to talk to me, but I didn't want to hear anything. I thought I was in love.

My family wanted me to get an abortion. I refused, and moved to a maternity residence. I stayed there until I had my son, Anthony. So here I was a 14 year old with a baby.

At first we moved in with Enrique and his family. When he began to mistreat me, I took Anthony home to my mother's.

I agreed with my mother to go back to school. I stayed in school for about 8 months, and hated it the whole time. It just didn't feel the same as before. There was no one to tell me how proud they were of me, and the school wasn't like Hunter.

I hated myself and I thought my parents hated me too.

I started hanging out with Enrique again. I stopped going to school and started using drugs, marijuana and cocaine. I'd never used drugs before.

Soon I was using drugs everyday. Then Enrique introduced me to crack. When I started using crack, I began stealing from my mother. She got fed up, and told me to either get some help or leave her house. So I left.

I was living on the streets and getting high with anybody. Some days I didn't eat or sleep. I didn't want food. All I wanted was crack.

I would walk the streets dirty, tired and hungry, crying thinking how I had ruined my life.

Finally I went home to my mother and told her I needed help. The next day, she took me to Phoenix House. I entered Phoenix Academy in July '87.

The first three months of my treatment, I was in total shock. There was so many rules. I couldn't smoke without asking, I couldn't put my hands in my pocket. I even had to get permission to go to the bathroom. I didn't want to hear about my negative attitude.

When I finally called my mother, the first thing I said was "could I come home?" She told me I had to stick it out. I felt so alone. I couldn't go home, and I didn't want to stay at the Academy.

I got so tired of being hassled about my behavior ... until one day I realized that I really wanted to change, but didn't know how. And I was afraid to ask for help. I didn't think I could change.

That's when I got serious about treatment, and learned that the staff and my friends really cared about me. They showed me that I could be a better person, and they would help me.

So after a lot of pain and tears, I have changed. I am now 21 and have been in Phoenix Academy for 22 months. I have grown up to be a responsible young woman, with plans and goals.

I will have my high school diploma in the fall, and plan to go to college.

I am grateful to Phoenix House for giving me a second chance. My old dreams were destroyed, but I have new ones; to be a responsible mother to Anthony, to make a career for myself; and a new life ... and, most of all, to stay drug-free.

I want to thank my mother for making me get the help I needed and I want to thank all of you for making sure Phoenix House was there for me.

THANK YOU!

Senator DODD. Michael, welcome.

MICHAEL. Thank you.

My name is Michael. I am 19, and I am a senior at Phoenix Academy. I have been in the program 9 months.

My problems with drugs began at the age of 15. I was a sophomore in high school. I was on the varsity basketball team and wrestling team and doing well in school. I had a lot of pressure from my parents to do better.

I resented the pressure and their strict rules.

Many of my friends started to smoke pot, and so did I. Doing drugs gave me the feeling of being free and seemed to make all the problems and pressures disappear—at least, until the high went away.

Over the next year and a half, my drug use increased. I was getting high every day. My life changed dramatically. I was coming home in the middle of the night. My relationship with my family worsened, and my grades in school dropped. I can remember a few times I came into my house high at about 2:30 a.m. on school nights and my parents, who were extremely nervous and upset, had stayed up waiting for me.

They would not stand for this. They suspected that I was using drugs. They insisted on a curfew. I argued and protested, and when they persisted, I left home.

The next year was a horror show. I started using cocaine. I dropped out of high school in my senior year. I found jobs and could not hold them. I stayed with my friends and manipulated my father into helping me get a place of my own. Finally, my father threatened to cut me off. I had no money, and I needed \$300 a week for cocaine. That is when I called my mother in desperation.

I knew the only way they would let me come home was if I agreed to receive help. My parents took me to a psychiatrist, and they convinced me that I needed treatment. The psychiatrist had read off a list of programs that I could go to, but he explained to me that Phoenix Academy was the best program on the list.

When I came to the academy, they told me the program lasted 18 to 24 months. I was shocked. I did not like this idea. I wanted to go to a 30- or 90-day program, but I could not understand why the psychiatrist and my parents would not let me.

I now understand why they would not let me. My first 30 days at the academy, I spent trying to adjust to the program. After 90 days, I still was not willing to accept all the ways I had to change. It is now 9 months later, and I am a better person than I was before entering treatment. This has not come easily. I have to work at it every day.

Phoenix Academy has given me the opportunity to finish high school. I will graduate this June and plan to go on to college.

I feel I have been very lucky, first, because my parents insisted that I get the help I needed; second, because I lived in New York State, where there are a number of treatment programs that will treat adolescents; and third, because my parents chose Phoenix Academy for me. Some friends of mine have not been so lucky.

Thank you.

Senator DODD. Thank you, Michael, very much.

[The prepared statement of Michael follows:]

PREPARED STATEMENT OF MICHAEL

My name is Michael, I'm 19 and I'm a senior at Phoenix Academy. I've been in the program 9 months.

My problem with drugs began at the age of fifteen, when I was a sophomore in high school. I was on the Varsity Basketball and Wrestling teams and doing well in school. I had a lot of pressure from my parents to do better. I resented the pressure and their strict rules. Many of my friends were starting to smoke pot and so did I. Doing drugs gave me the feeling of being free and seemed to make all the problems and pressures disappear, at least until the high went away.

Over the next year and a half my drug use increased. I was getting high everyday, my life changed dramatically. I was coming home in the middle of the night, my relationship with my family worsened and my grades in school dropped. I can remember a few times I came into my house high at about 2:30 a.m. on school nights and my parents, who were extremely nervous and upset, had stayed up waiting for me. They wouldn't stand for this. They suspected that I was using drugs. They insisted on a curfew. I argued and protested and when they persisted, I left home.

The next year was a horror show. I started using cocaine, I dropped out of high school, I found jobs and couldn't hold them. I stayed with friends and manipulated my father into helping me get a place of my own. Finally my father threatened to cut me off. I had no money, and I needed \$300 dollars a week for cocaine. That's when I had called my mother in desperation.

I knew the only way she would let me come home was if I agreed to receive help. My parents took me to a psychiatrist and they convinced me that I needed treatment. The psychiatrist had read off a list of programs that I could go to but he explained to me that Phoenix Academy was the best program on the list.

When I came to the Academy they told me that the program lasted 18 to 24 months. I was shocked! I didn't like this idea. I wanted to go to a 30- or 90-day program but I couldn't understand why the psychiatrist and my parents wouldn't let me.

I now understand why they wouldn't let me. My first 30 days at Phoenix Academy, I spent trying to adjust to the program. After 90 days I still wasn't willing to accept all the ways I had to change. It's now 9 months later and I'm a better person than I was before entering treatment. This hasn't come easily, I have to work at it every day. Phoenix Academy has given me the opportunity to finish high school. I will graduate this June and plan to go on to college.

I feel I've been very lucky. First because my parents insisted that I get the help I needed. Second, because I lived in New York State where there are a number of treatment programs that will treat adolescents. Third, because my parents chose Phoenix Academy for me.

Some friends of mine haven't been so lucky.

Thank you.

Senator DODD. I appreciate the comments from both of you. And I would just hope, aside from your specific responses to some questions that Senator Coats and I and others may have for you—talk about increasing your burdens, but I will tell you something, there is no better group of people to talk to adolescents than people like yourselves. They have all seen the Senator; you know what kind of impact I have when I talk about it—and with all due respect to Dr. Rosenthal and others who work in these fields, I can tell just by looking in a student's eye, they are looking at me, and I am just not getting through. But people like yourselves can really make a difference. And my hope would be that in the case of both of you, as you are both getting your lives together, you might be willing to put some of that experience to work.

I cannot tell you how meaningful it would be for you to be able to go back into schools and to be able to talk to people about your own experiences and how there is hope. I think an awful lot of it is the feeling that, as you had, there just is not any hope.

Dr. ROSENTHAL. Senator Dodd, we do that on a regular programmatic basis. We have an education division within Phoenix House that goes out to as many as 100 schools a year and sees as many as 35,000 or 40,000 kids in their classrooms. Our counselors work along with the youngsters who come through the program. So that would address that point you are making about the trustworthiness of peers and being able to talk freely.

Senator DODD. Well, I appreciate, again, both of your testimonies.

Dr. Lewis, we welcome you, and we thank you for coming all the way from Indiana to be with us here—from a distinguished university, Purdue—and we are anxious to receive your testimony.

If you might follow sort of the same guidelines and perhaps paraphrase, and obviously, the full text of your remarks will be made a part of the record.

Dr. LEWIS. Surely; I will cut it short.

Senator Dodd, committee members and others of you concerned about adolescents, families and substance abuse, thank you for giving me the opportunity to speak today on a topic that is very important for me, not only as a researcher and educator, and a sociologist of the family at Purdue University—and I am also a family therapist; I am a clinical member of the American Association of Marriage and Family Therapists—but as the father of two sons and a grandfather of one young boy, Scott Allen, only 2 years old, who himself someday in the future may be confronted with difficult temptations related to using alcohol and drugs.

One of my colleagues has reminded me about two surveys done in the United States 40 years apart, one done in the 1940's and the other done in the 1980's. In the 1940's study, when I was in high school, teachers listed the 7 top discipline problems in public school as: talking, chewing gum, making noise, running in the halls, getting out-of-turn in line, wearing improper clothes, and not putting paper in wastebaskets. We think of them as trivial.

In 1980, the same survey was done, and they listed the 7 top discipline problems as: drug abuse, alcohol abuse, pregnancy, suicide, rape, robbery and assault, and rounding out the list are arson, gang warfare and venereal disease.

I would say that in 40 years we have had quite a change in problems in schools.

Certainly, my own parents in the 1940's probably would never have thought that I or my children or their great-grandchildren would have any of these problems, and yet they do.

For many of our children and adolescents today, these are everyday issues, concerns, and temptations.

Mr. Chairman, 3 colleagues of mine at Purdue University—Drs. Fred Piercy, Douglas Sprenkle, and Terry Trepper—and myself conducted, for the last 4 years, a research study whose primary purpose is to get teenagers off drugs and to prevent their younger siblings from ever becoming involved in drugs. The study has been funded by the National Institute on Drug Abuse for the last 4 years.

We began our study back in 1985 by locating 127 teenagers throughout Indiana who had drug-related problems. We randomly assigned these adolescents to 3 treatment programs—they did not have a choice. These outpatient intervention programs lasted only 12 weeks. It is a very brief program, but it is also cheaper than some other programs.

These outpatient intervention programs, one of which was family-centered, demanded that all the members of the adolescent's family come together and meet for treatment sessions. The other one of these programs, we could call an educational model. That model is a didactic one which educates the entire family about drugs, about family relationships, and how these two work together or do not work together.

The family therapy model, as we call the Purdue Brief Family Therapy Model, is not really new, but it is culled from some of the existing therapy models of therapy for families which have been effective both with juvenile delinquents and with adult heroin addicts.

The third program we assigned some of our youth to was called "treatment as usual". This was whatever the agencies with whom we worked usually provided their teenagers if they had them at all as clients. In most cases, this treatment was individual, drug-based counseling of the adolescents.

There are many details I could share with you about this research. In short, however, I will just state the final findings. The two brief family-based drug interventions together seemed to reduce about one-half of the adolescents in terms of their drug use who received them. We suspect that this was due partly to the fact that both of these outpatient interventions focused on the treatment of the entire family—and I would like to speak about this if there are questions—rather than treating just the individual, who may then go back to the same family from which he or she came, which is still in disruption, still dysfunctional, and again partake of the same drug addiction. So we treated the whole family, and we believe this is going to sustain the effects for a longer period of time than if we just worked with one individual.

One of our better findings that gives us all hope is that 44 percent of those who went to the family therapy sessions moved from hard drugs to no drugs at all within the 12 weeks.

However, we do have some failures, too; I think every program has its failures. We can talk about that, too.

Mr. Chairman, I have been working in the family and substance abuse area for more than 10 years now. When I first became active in this area, there were very few drug programs that ever thought to bring in spouses, parents, grandparents and to put them directly into the treatment of a drug user.

However, today, family therapy is the treatment of choice. In many of the studies that have been done with drug users, as we found evidence in our studies—and so have others—adolescents in treatment focused on family groups have found decreased drug dependence and less recidivism. In contrast, if an individual is treated individually, and his or her family is not changed, the adolescent may return home to play out the same roles that they were playing earlier that led up to the addiction.

In summary, I assert that family therapy appears to be a potent and viable method of treatment. It has helped a majority of the adolescents that we worked with greatly reduce their drug use, or completely get off drugs.

Our own particular family therapy intervention program, we believe, is effective, is ethical, tested, and of low cost. This might be of interest to Senators such as yourself. Since it is an outpatient modality, it can be replicated in almost any type of outpatient setting; therefore we have developed to help us in this regard quality videotapes which can aid drug counselors and family therapists who have not used the program before to further train themselves in our models.

We have worked with many kinds of adolescents and families in this project. We have given our program to both Black and White teenagers, to rich and poor, better-educated, less-educated, urban and rural kids. And by the way, we found out that the most serious drug use was among the rural youth, not the urban youth that we thought would be the case.

We do not, of course, have all the answers yet. For example, we are still analyzing our data to find out how this success rate varies by ethnic group. We also do not know whether it works as well with single-parent families as it does with two-parent intact families. But we hope to know some of these answers within the next year. We are not sure whether our family therapy program will be as effective for prevention as well as it is for treatment. We still need a few years to know how well it has worked in preventing a younger sibling in the family from developing drug addiction.

Thank you again for letting me speak to you and share the results of our earliest study.

Senator Dodd. Thank you very much, Dr. Lewis.

[The prepared statement of Dr. Lewis follows:]

PREPARED STATEMENT OF DR. ROBERT A. LEWIS

Mr. Chairman, committee members, and others of you who are concerned about adolescents, families and substance abuse. Thank you for giving me the opportunity to speak today on a topic which is very important to me, not only as a researcher and educator, a sociologist of the family at Purdue University, but also as a father of two sons and a grandfather of one young boy, Scott Alan, who himself someday in the future may be confronted with difficult temptations related to using alcohol and other drugs.

One of my colleagues, Dr. Fred Piercy, has reminded me about two surveys done here in the United States, one done in the 1940s and one done in the 1980s. In the 1940 study (when I was going to high school), teachers listed the top seven discipline problems in public school as talking, chewing gum, making noise, running in the halls, getting out of turn in line, wearing improper clothes, and not putting paper in waste baskets. In the 1980 study a similar survey listed these top seven discipline problems: drug abuse, alcohol abuse, pregnancy, suicide, rape, robbery and assault. And, rounding out the list are arson, gang warfare, and venereal disease (Will, 1987). This last list of school problems are problems that my own parents in the 1940s probably would never have thought to be possible problem areas for their own children, grandchildren or great-grandchildren. And, yet for many children and adolescents today these are everyday issues, concerns and temptations.

Mr. Chairman, three colleagues of mine at Purdue University, Drs. Douglas Sprenkle, Fred Piercy, Terry Trepper, and myself have conducted during the last four years a research study whose primary focus is to get teen-agers off of drugs and to prevent younger siblings from ever becoming involved in drugs (Lewis, Piercy, Sprenkle and Trepper, 1989). This study has been funded for the past four years by the National Institute on Drug Abuse. We began the study back in 1985 by locating 127 teen-agers throughout Indiana who had drug-related problems. We randomly assigned these adolescents and their families to

only one of three treatment programs. These outpatient, intervention programs lasted 12 sessions/weeks. Two of the programs were family-centered programs, which demanded that all members of the adolescents' family needed to attend the treatment sessions. One of these family-centered programs was a special kind of family therapy. This model, The Purdue Brief Family Therapy Model, is not really new but was culled out of already existing therapy models which have been effective with both juvenile delinquents and adult heroin addicts. The second family-oriented program was an educational intervention, a family and drug education program known as TIPS (Training in Parenting Skills). The third program was what we call "treatment as usual," that is, whatever the agencies with whom we worked usually provided their clients. In most cases, this treatment was individual-based drug counseling of adolescents.

The Purdue Brief Family Therapy Model is a brief, 12-session program which integrates some of the most effective elements of structural, strategic, functional and behavioral family therapies to stem the current drug abuse of an adolescent and prevent the development of drug abuse by a younger sibling. It has been geared to help a therapist gain entrance into a family, understand the family dynamics and modify the dynamics in ways that will reduce adolescent substance abuse. In short, the goal is to modify or change the entire family system into a healthier, supportive environment. In sum, the therapy attempts to: a) decrease a family's resistance to drug treatment; b) redefine drug use as a family problem; c) re-establish appropriate parental influence; d) interrupt dysfunctional sequences of behavior; e) assess the interpersonal function of drug abuse; f) implement change strategies consistent with the family's interpersonal functioning; and g) provide assertion training skills for both the adolescent and siblings to resist peer pressures to engage in chemical abuse.

The Training in Parenting Skills (TIPS) Program is also a twelve-session, educational intervention program. This cognitive-based, instructional intervention program uses family and drug education strategies to provide information to all family members about addictive drugs, the effects of these drugs upon individuals and entire families, and methods family members can use to help eliminate drug use. This model incorporates a view of chemical-abuse as a chronic problem/disease which is cumulative and progressive and potentially may lead to death. It uses educational, not confrontational, treatment methods. As with Alcoholics Anonymous and Al Anon, its ultimate goal is total abstinence from all chemical dependency.

There are many more details that I could share with you about this research. In short, however, the two brief, family-based drug interventions together appeared to reduce the drug use of nearly one-half (46%) of the adolescents who received them. We suspect that this success was due partly to the fact that both of these outpatient interventions focused on the systemic treatment of entire family groups. In contrast, however, the family therapy intervention seems to have been more effective in significantly reducing adolescent drug use for a greater percentage of the adolescents (54.6%) than the family education intervention (37.5%). An even more dramatic result of the

study was this: Although more than twice as many adolescents in the family therapy condition (40.9%) were hard drug users at their pretest, twice as many of these hard users (44.4%) moved to no use at all by the posttest time, compared to only the 25% of the hard users in the family education condition who moved to no drug use.

Mr. Chairman, I have been working in the family and substance abuse area for more than ten years now. When I first became active in this field, very few drug treatment programs actually brought spouses, parents or other family members directly into their treatment of the identified patient. Today, however, family therapy is the treatment of choice with most drug abusers (Coleman & Davis, 1978). And, today, there is a growing body of research evidence (Szapocznik, Kurtines, Foote, Perez-Vidal & Hervis, 1986; Stanton & Todd, 1982) which has revealed that systemic (family-systems centered) drug interventions and treatments are very effective in getting family members off and keeping them off drugs (Lewis & McAvoy, 1984).

For instance, there is evidence that, in families given family/systemic-based interventions or treatment, there is a higher treatment success rate, that is, decreased drug dependence and less recidivism. In contrast, if an adolescent is treated individually and his/her family system has not changed, the adolescent may return home to play out the same roles which earlier had fostered his/her addictive behaviors. The family systems approach views an adolescent's addiction as possibly serving a function/role in the psychosocial economy of a family. For example, an adolescent may use drugs to gain his or her parents' attention and to get them to stop fighting (Haley, 1980).

The addition of other family members in treatment, however, may greatly add to the complexity of the drug interventions. Yet, this addition often gives much greater leverage for sustained and successful drug treatment (Lewis & McAvoy, 1984; McAuliffe, 1975). This is because one of the strongest motivations for eliminating drug use may be a drug-abuser's desires to maintain his or her love and family relationships.

In other words, family "love bonds" can be utilized to work for successful drug treatment as well as to work against treatment. That is, in some cases the addiction of one family member may directly contribute to (contaminate) the addiction of another. Thus, there is often an interaction between addictions and meaningful relationships in that effective family relationships may be used to reduce or eliminate individuals' addictive behaviors. It is only when one views the interplay of meaningful relationships and addictions that one may make full use of the motivations inherent in good family relationships which may help addicts overcome their addiction (Lewis & McAvoy, 1984).

In summary, I assert that family therapy appears to be a potent and viable treatment program which has helped the majority of our adolescents get off or greatly reduce their drug use. Our own particular family therapy intervention program, we believe, is effective, tested, ethical, and low cost, since it is an outpatient modality. It can be replicated in most any type of outpatient setting. Furthermore, we have developed quality videotapes which family

therapists and drug counselors can use by themselves to further train themselves in our model.

We have worked with many kinds of adolescents and families in this project. We have given our program to both Black and white teen-agers, to rich and poor, to better and less-educated youth, and to urban and rural kids. But, we don't have all the answers, yet. For example, we are analyzing our data right now to see whether our therapy program is as effective with teen-agers from all ethnic groups and whether it works as well with single parent families as it does with intact (two-parent) families. We hope to know some of these answers within the next year. We also are not as sure whether our family therapy program is as effective for the prevention of adolescent substance abuse as it is for treatment. We will still need a couple of years to know how well it will prevent a younger sibling in the families from developing a drug addiction.

Again, thank you for inviting me to speak before you and to share the results of our latest study of adolescents, families and substance abuse.

Senator DODD. First of all, I certainly wish you success. I hope your statistics will prove that, in fact, it can make a difference because certainly, as you point out, the costs alone, when we discuss numbers here, are staggeringly high.

But you have anticipated a couple of questions, too, in terms of the data. Obviously, having a family makes a difference. We are finding an awful lot of kids today who do not know who their fathers are, and their mothers may not be substantially older than they are in some cases.

On the average, how long had the abuse gone on—in other words, someone who had experimented with cocaine, were they addicted, or addicted to crack, were they casual users—did you look at the length of the abuse in terms of the rate of success that you had?

Dr. LEWIS. We have the whole gamut from teenagers who are just beginning to use substances, maybe got caught in the schoolyard using pot. We have that extreme, and we have kids who have been using drugs since they were 14, and they are 20 now. So we have the whole gamut.

We still have not found yet, because we are still working through the data—this is fairly initial early stage—we suspect, as most studies have shown, the longer you have been in the addictive process, the more difficult it is going to be to get them off.

Senator DODD. So your concern would be that the 12 or 14 weeks applies more to the casual user than—

Dr. LEWIS. It would probably be more effective and more easily seen, the changes and successes, with those who have not had such a long addiction problem than those who would need much more intensive, longer-term therapy.

Senator DODD. Dr. Rosenthal, what is your opinion?

Dr. ROSENTHAL. Well, I think there are a couple of important related points here. We at Phoenix House have found, over the past 15 years, that family involvement is critically important to retaining someone in treatment and in the ultimate success of treatment.

As Dr. Lewis said, just treating somebody and working with them individually and then sending them back to a dysfunctional family does not work. In fact, with adolescent programs, both outpatient and residential, it is a requirement that families participate, not just biological mothers and fathers, but stepmothers and stepfathers and half-sisters and half-brothers. And very often, one adolescent will have 12 or 16 people around him or her at some point, so that we can deal with that whole system.

We also did some research on retention and found that as we got family members involved even earlier, it helped our retention figures. So that I think in any dimension of treatment and in any strategy of treatment, any of the old notions that you could sort of take a youngster away and work with them and not look at the context of family have all been discarded.

Senator DODD. Can you help us with the numbers game? This is always unfair to ask, and there is a danger in all of these. We have seen it happen in other areas of legislation where numbers get bandied about, and it is important for us to get some sense of proportion of the problem in terms of the kinds of requests that Senator Coats and I have to ask of our colleagues on these things.

I know it is difficult to nail down exact numbers. We have this number of 6 billion adults and adolescents that has been thrown around as people who require some form of treatment——

Dr. ROSENTHAL. I think that is misleading——

Senator DODD. Help me on some of these things.

Dr. ROSENTHAL. Let me see if I can give you a context, or a prism, through which to look at these numbers.

Senator DODD. All right.

Dr. ROSENTHAL. It is exceedingly rare—in my 22 years at Phoenix House, I can count on one hand the number of youngsters or adults who have awakened one morning, looked at themselves in the mirror, and said, "I cannot stand who I am, I cannot stand who I have become. I hate it that I lie to everyone who loves me, and I have got to go and do something about changing my life." What invariably happens is a loved one, father, mother, wife, husband, employer, judge, somebody says to the user: "You can't do that anymore. You have got to stop. I am going to put you out of school. I am going to put you out of this house. I am going to put you out of your job. I am going to put you in jail." Therein begins the engagement.

So most people come forward not because they want to, but because somebody else is coming behind them.

Now, if we are successful in our work, we change that early motivation, which was somebody else's idea, into the idea of the person who remains and who engages and begins to say, "You know, those people were right. There is something here that I have to do for me, and I am now staying here for me. I am not staying anymore because mom thought it was a good idea, or because the judge said I could do this instead of jail."

So when you think of the motivation process that way, it is then different than saying, well, we have out there some 6 million people who are probably so dysfunctional that any group of experts assessing them would say that they need treatment. That does not mean that they are going to treatment. And I guess as we look at this at any time, probably only 10 percent or so of the numbers are available.

Now, if society changes the groundrules, if employers articulate that indeed NBC and Consolidated Edison and the United States Army and everybody else are not going to tolerate, then the numbers start to change because then people start to seek treatment because they know that their jobs and their livelihood may depend on it.

If communities toughen up, if schools toughen up—that is why when you begin prevention programs, and you make teachers and parents aware, and they start to look more critically at the student body, you immediately surface cases that need treatment which were before that going undetected.

Senator DODD. Dr. Lewis, do you agree with that?

Dr. LEWIS. Well, I am not a statistician, and I cannot really give you those facts, figures, that I think you want. I would like to address one point, though, which is that I think we need many different kinds of programs. One is not going to work for one kid that works for another. It is not throwing our money, perhaps, as citizens into one particular kind of program. I do not think that is

going to work. We are going to have to try everything and impact all kinds of organizations.

For us, we try to impact the family because we think if you can change the family to be more functional, then that kid has a much better chance of going for a longer time without more treatment. The family will become the treatment unit if we are successful.

But I think you could not have, perhaps, people at more extreme ends of the treatment program here. I think we are representing different programs at the extremes, perhaps, and what works with one may not work with the other—do you agree?

Senator DODD. Dr. Rosenthal.

Dr. ROSENTHAL. I don't think I would agree with that. I think that if we looked at how dysfunctional a youngster might be that we would agree that there should be a series of options from the least intrusive that are outpatient options that would involve the family to the more restrictive programs at the other end of the spectrum, which are residential; and then, depending on family strengths, on individual strengths, on drug use patterns, we would make an assessment of where in this continuum someone belongs.

Senator DODD. So the issue ought to be based on the specific needs—

Dr. ROSENTHAL. Of the individual.

Senator DODD [continuing.] Rather than just sort of assuming that no matter which one you choose, it is going to work.

Dr. ROSENTHAL. That's correct. And I do agree with Dr. Lewis' statement that you need an array of different kinds of services. I did not mean to imply with any of my testimony that I think there is a single model which is useful for a person. That is hardly the case.

Senator DODD. Well, it will be interesting to see the statistics. I was sort of intrigued by what Lisa and Michael had to say, that at the first 30 days or 60 days, if the program had ended there, am I to conclude from what you both said that in your assessment of yourselves, you would still be using drugs—that you would not have made it?

LISA. Yes. I know I would not have. I did not want to stay—and I did not want to go in the first place, but my mother pushed me in. And after a while, then I wanted to be there.

Dr. ROSENTHAL. We have very good data on this, Senator, looking at kids who have left after 30 days or after 90 days or after 6 months or 12 months, looking at what happens. And what we have learned in doing research on as many as 5,000 people who have been in treatment for these different lengths of time is that success is related to time in treatment. It is almost like a dose-related curve. Those people who stay less than 6 months, that is—

Senator DODD. And to length of abuse by the patient?

Dr. ROSENTHAL. Well, yes—

Senator DODD. I am asking that. Tell me if I am right or wrong?

Dr. ROSENTHAL. Anyone who has come into our residential program has generally had at least 3 years of abuse. We are not talking about somebody who was a casual abuser for a short period of time. To qualify for residence in Phoenix House, you have to have been out of control for some period of time.

Now, if you look at that population who is deemed dysfunctional enough to warrant long-term residential care, and then you ask, well, what happens to those people, because not everybody stays for 12 months—many leave against advice early—our success is really measured by time in treatment. If you look at people who were there only 3 months, and you find them 5 years later, most of the time that 3 months is going to turn out not to have made any difference in their lives.

Senator DODD. What are the statistics—roughly? We are assuming a base of 3 years of abuse.

Dr. ROSENTHAL. Right.

Senator DODD. I think it is a very pivotal question in terms of the time in treatment, in my view.

Dr. ROSENTHAL. Time in treatment is pivotal in determining outcome. With people who remain 12 months, 70 percent of them 5 years later will be successful.

Senator DODD. Twelve months.

Dr. ROSENTHAL. Twelve months. At 18 months, it jumps up to 90 percent. At less than 6 months, we do not see much of a treatment effect.

Now, these findings that we did in our research have been replicated by other behavioral scientists in other centers, looking at both residential treatment programs and nonresidential, outpatient treatment programs. So that time in treatment is a critical variable.

That is why I said earlier in my testimony that when we see that someone has only gotten 30 days of treatment and then has been released, hoping that they would be picked up by AA or NA or outpatient therapies—which often are not covered by insurance policies most of the time—then those people are at risk because they have had, really, insufficient treatment.

A lot of the notion, I think, that we have in the country that treatment is not sufficiently effective is based on the fact that we have seen a lot of people fall again and again and again when, in fact, the treatment to begin with was insufficient in length of time.

Senator DODD. Can you give me some sense of the percentage of adolescents we are talking about—I take your note of concern about that number and getting to tied to the 6 million number—in other words, you are both suggesting it is at least that number, and that is a best guesstimate of the low side; you both agree that that number is probably much higher. And how many of those are adolescents?

Dr. ROSENTHAL. If you are defining adolescence as age 13 to 19, probably 45 percent of that number are adolescents. After all, drug abuse is a disease of adolescents and young adults. If you look at our adult populations in Phoenix House, the average age is 23½. If you look at our adolescent populations in residence in California, the average age is 15½; in New York, it is 17.

Dr. LEWIS. Then there are the older people who are using prescription drugs and so forth, probably overdosing. You do not see those people, either; they are a little more invisible, perhaps do not cause some of the problems that adolescents cause.

Dr. ROSENTHAL. I think one of the things that you were trying to elicit which may not have come out as clearly as I think I would

like it to when you were talking with Dr. Johnson is the fact that while we talk about 250,000 treatment slots, when you look at how many of those slots are methadone slots for adults—

Senator DODD. One hundred forty-eight thousand IV drug users.

Dr. ROSENTHAL [continuing.] Right—if you look at how many of those slots are outpatient slots for adults, and you look at how many of those slots are residential slots for adults, it leaves very little in the way of resources for adolescents.

So again, Los Angeles has 93 beds; New York State has less than 500. We probably do not have 1,200 beds nationally for kids 13 to 19 who need long-term residential care.

Senator DODD. How many should there be in New York, for instance, which you are familiar with? You have 93 in California and 500 in New York State. What would be your guess in both those States that you would need?

Dr. ROSENTHAL. In the thousands.

Senator DODD. For residential.

Dr. ROSENTHAL. Just as you look at our adult prisons, and you say, well, 70 percent of the prisoners are substance abusers and ought to be involved in some kind of treatment, if you look at youth detention centers, if you look at any of the places that are holding kids that are out-of-control in our society, 80 percent of those kids are abusing kids, and we don't have any services for them.

Senator DODD. Senator Coats.

Senator COATS. This is interesting testimony, and I really appreciate both of you appearing and giving us this information. I guess one of the reasons I was so excited about Dr. Lewis' program and testimony is that I thought it might give us a means of treating the problem in a relatively low-cost way. You were talking about outpatient, 12-week therapy with some fairly impressive success rates. You said certainly you have had your share of failures, as I assume every program does, but that is a far cry from the Phoenix House program, which is very intensive institutional long term. I think the estimated cost—I think your figure was \$18,000 per year per person which, if we use the 6 million figure—and I realize that that now is a floating figure here—puts us at a cost that is just astronomical, because it is well into the hundreds of billions of dollars. Just 6 million times \$18,000 is \$108 billion. And I know you both discussed the range, that there are different treatments needed for different people at different stages and in different family situations and so forth. But unless we can move to something like Dr. Lewis' model, I just do not know how we are going to begin to provide the kinds of slots that you are talking about for your type of program.

Dr. ROSENTHAL. Senator, I do not think that we need to develop 6 million treatment slots in America. In 1962, less than 2 percent of the population of the United States had ever used an illicit drug; by 1982, we had 38 percent of the population having used it.

I mean, we have had a vast cultural shift of drugs becoming normal in our culture. If we continue to move in the many ways that we have in the last 5 years and denormalize drug use in America, we will see most people in the mainstream not using drugs.

I think the data coming out of the high school surveys are encouraging. At the same time, we need to build up a bigger capacity for treatment. We have a long way to go that I think is affordable and manageable and which will give us results without thinking about elaborating 6 million treatment slots.

Senator COATS. Dr. Lewis, comment a little bit more about the applicability of the family therapy approach, the 12-week outpatient. Who can we extend that to? How far can we extend that? You said you tested it on urban and rural young people, and poor and wealthy, and so forth. But how far can we take that in dealing with the problem, and then where do we need to turn to the Phoenix House type of approach—and what is in between?

Dr. LEWIS. There is quite a bit in between. Unfortunately, though, the places in between are not doing any research for the most part. Speaking well of the research that is being done, but there are really a very small number of treatment programs over the country that I am aware of that are doing any kind of research. It is sort of that people believe in their model; they believe that this program works. We have never even sent postcards to find out how people are doing. But I think there is going to be a need for both of these models and much in between.

Our own model, I think, will work for any kind of family where people are concerned about their kids. It can be single parents, and it can also be very extended families. I have seen some of the most loving, warm families where they have grandmother and grandpa there, too, and they care as much about this teenagers as the siblings and the mother and father do.

So I think our program can be used with any group that can be called a family, even single parents. I think they have a double strike against them because they cannot unite to present a front against the teenager when that needs to be done.

Dr. ROSENTHAL. With all respect to Dr. Lewis, we have probably treated more than 43,000 in the last 22 years. I doubt that any of those people, given the degree of dysfunction that we saw, would have been successful or appropriate candidates for a family therapy intervention.

I think it is a very useful modality that should be used on a thoughtful and discriminating basis. But I do not think it holds promise for the hundreds of thousands of out-of-control and dysfunctional kids that are in our cities and, as Dr. Lewis points out, in our rural areas as well.

Senator COATS. Dr. Lewis, do you think your model is more applicable to small-town America, rural America, where some family structure is perhaps more available or intact than, say, an inner-city problem with a high percentage of unwed mothers or high percentage of single parents living in poverty?

Dr. LEWIS. Speaking of probabilities, I would say yes. The more intact the family is, perhaps the better our model will work.

Senator COATS. Or the more available the extended family is.

Dr. LEWIS. That's right. But I still think that we can work with smaller units—if people care about each other, it will work.

Senator COATS. Dr. Rosenthal, you said that you were encouraged, and I am too, by the declining numbers of kids in school

using drugs and that that trend was pretty universal except New York City—or did I misunderstand you?

Dr. ROSENTHAL. I was saying that New York State had done a household survey, and the household survey is quite at odds with the data that the NIDA survey is showing. It is not nearly as encouraging in showing this decline.

Senator COATS. OK. So it is a State study.

Dr. ROSENTHAL. It is a State study in New York compared to the national high school study. One is looking at households in New York State, and the other is looking at high school students.

Senator COATS. OK. And therein lies the distinction between those that stay in school and those that drop out?

Dr. ROSENTHAL. No. There is no study that has been able to pick up the dropouts and look at what the incidence is among dropouts. So that really is a dark side that we do not know very much about.

Dr. LEWIS. But a very important side if you think that in some communities, half the youngsters do not get through high school. So we do not know about that half.

Senator COATS. Well, like most problems, it is always more complex than you try to make it. I suspect the causes are more complex than we would like to think they are, and the treatment needs are more complex than the variety of things we are dealing with.

I thank you both for your testimony.

Senator DODD. Thank you very much.

Let me just ask one more question of Lisa and Michael, because I am always curious. I do a lot of high schools in my State on Mondays, and I always ask the juniors and seniors whom I usually speak to in public high schools: At home, how effective is what Washington is putting out in terms of trying to discourage young people from using drugs? We had the "Just Say No" program, which I am sure you are familiar with, for example.

That is No. 1. Then, if you could design a program that would reach the people that you were familiar with, growing up, who are today still out on the streets and using this stuff, which do you think is apt to work best; what would have reached you? And second, if you have got people on the stuff, what is the most effective way of trying to get a message through in light of what Dr. Rosenthal has said about getting people to get into some sort of treatment, whether it is family treatment or very intense residential treatment; what would you recommend?

Michael, let's start with you.

MICHAEL. It is very difficult to come up with an answer, but my opinion is basically, more public speaking as far as an individual like me or Lisa or people who work in the programs, giving more public speeches, maybe. And the slogan, "Just Say No", I feel that was a very good idea. I have seen it on TV many times. But the only problem is that at the point in my life when I was still using drugs, I saw that, and if you are that involved, it is not going to suddenly change your mind as far as saying, "Oh, okay, well, I need to get some help."

Senator DODD. That is what I mean; if you haven't started yet, what works to keeping you off?

MICHAEL. Well, for me, my parents. They were very supportive, and they pushed me to the limit. For others, I really could not tell

you, because this is my own situation, but family, teachers, even judges—those are the people who would be more influential.

Senator DODD. But a group of these young people said to me, "Senator, part of your problem is that the messages we get on this are always negative." Obviously, just saying "no" has its effect. But among younger people, it is not only them having to say "no" to themselves, but saying "no" to friends, saying "no" to peer groups and everything else, and so there needs to be a more positive message that is coming out. I am not saying that was consistent, but I heard that quite often. What are the alternatives to this? What does life offer in alternatives to this where it doesn't become a difficult thing to say "no", it becomes popular to say "no". In other words, it is not saying "no" to that, it is saying "yes" to something else.

I do not know if I am expressing their view very well, but that is the sense I had, that maybe our messages are too negative on trying to discourage people from getting into this in the first place, and then in fact there is almost a reaction among young people to a negative message, to just head in absolutely the opposite direction for the sake of doing it, at least initially in some cases.

Do you understand what I am saying? Do you agree with that, Lisa, at all?

LISA. Yes.

Senator DODD. You came from a good family; you had a terrific mother who cared deeply about you.

LISA. Right.

Senator DODD. And your parents cared, Michael—you don't argue about that at all, do you?

MICHAEL. No, not at all.

LISA. But it was like my family was too good. My mother did not really know much about drugs, and I was not educated. I didn't know anything about it, and I didn't believe that it would do anything to harm me until it was too late. So I think that if I had known a little more about it and what it would have done to me, I don't think I would have gotten into it.

And what you were saying about people like me, going to schools and so on, I had never talked to anybody who went through anything, so I had to find out myself.

MICHAEL. I would like to add one thing as far as that goes. One thing that could be beneficial toward prevention of drug abuse is with the parents. My parents, I know they did not really know too much about it at all. There was a period when I was using drugs, and they had no clue as to what to do, how to notice their son or their daughter was on drugs, and how to prevent it and help them. And it took a while for them to find out from me, acting out and doing the things that I did, to make them realize something was wrong.

Dr. ROSENTHAL. We cannot underestimate the tendency for parents to deny. It is just an extraordinary problem, and we have to keep addressing it. We have to keep inoculating parents as a way of having them know, having them consider it.

One thing that parents may want to consider, which should be talked about as part of any public debate, I think, is whether parents ought to ask pediatricians as part of routine exams to test for

drugs. Drug abuse is the most common disease in kids aged 10 to 20. Now, let's not argue about kids 17 to 20 and what their rights might be. But certainly a parent who has got a 13- or 14-year-old ought to know in addition to the fact that their youngster does not have sugar in the urine that the youngster does have traces of marijuana.

I think that when kids go in for routine school exams, or kids go in for an exam for bronchial pneumonia or anything else, that part of a routine screening ought to be a drug screen. I think parents ought to ask their pediatricians to do it. I think they ought to get that information. I don't think that necessarily has to become part of a public record so that we are in a debate about invasion of privacy and documentation in school records and so forth, but I think parents ought to know that, and it ought to become part of their consciousness about their children's health.

Senator DODD. I suspect you often face the same problem of the parent who doesn't really want to know the answer to that question, hoping somehow it may go away if they even suspect it is around.

Dr. ROSENTHAL. I don't know that some of them even know that that is available, that is something that they could find out about. For too many years, pediatricians have sort of thought that drug abuse is not their realm, is not something that they as pediatricians ought to be looking at, so they are not looking at it, parents are denying it, and the most important resource that a parent has in terms of his or her child's health is now not an active agent in this dreadful illness.

You know, when people start to look and make the demand, the figures change. When the Defense Department and the Army and the Navy and so forth initiated policies 5 years ago that drug abuse would not be tolerated, that it would be tested for in the military, the incidence figures went down from 23 percent to 3 percent—a dramatic change. When organized baseball took on this position, the figures went down from 18 percent of people in organized baseball to less than 3 percent.

We can change the figures dramatically.

Senator DODD. I think that is an excellent suggestion.

I want to thank you all. Dr. Lewis, if you would, we would like to get that additional data from your study as more information comes in. I am particularly interested in the notion—obviously, you both give me a sense that maybe I'm on the wrong track—but that length of abuse period, and then treatment, and obviously extending the period of treatment, it seems to me fills out the formula. I would like to get some sense of, from the surveys you have done, how long the period of abuse was and then the treatment response time in terms of success rate. I think that would be interesting to look at.

Again, we thank you both, Dr. Lewis and Dr. Rosenthal. Again, happy birthday to Phoenix House and congratulations on all your successes. I know there are a lot of people out there today who are healthy and productive citizens because of Phoenix House.

And Lisa and Michael, congratulations. You did a first-rate job as Senate witnesses.

Senator DODD. Our next panel consists of Lois Olson, director of the Division of Alcohol and Drug Abuse of the Missouri Department of Mental Health; Dr. Jeanne Wurmser, executive director, CPC Mental Health Services, Inc., and past president of the Association of Community Mental Health Centers in New Jersey; and Leigh Rudd, a parent from Greenwich, CT.

We thank all of you for being here today and for being so patient. I know you have lengthy written statements, but if you could just cut right into the heart of the thing, and we will take your statements and read them.

Ms. Olson.

STATEMENTS OF LOIS OLSON, DIRECTOR, DIVISION OF ALCOHOL AND DRUG ABUSE, MISSOURI DEPARTMENT OF MENTAL HEALTH; DR. JEANNE A. WURMSER, EXECUTIVE DIRECTOR, CPC MENTAL HEALTH SERVICES, INC. AND PAST PRESIDENT ASSOCIATION OF COMMUNITY MENTAL HEALTH CENTERS, EATONTOWN, NJ; AND LEIGH RUDD, PARENT, GREENWICH, CT

Ms. OLSON. Thank you. I really appreciate having the opportunity to testify in front of you.

It has been very interesting for me to sit here and to listen to all the testimonies so far today. It is also very difficult for someone, as all of us are, who are so committed to sit back there and be quiet when all of this is going on. You really want to get into the fray.

Let me first of all say that my name is Lois Olson. I am the director of the Division of Alcohol and Drug Abuse for the State of Missouri, and I am also here in the capacity as vice president for Alcohol Issues for the National Association of State Alcohol and Drug Abuse Directors.

NASADAD is the organization that is made up exclusively of the officials designated by the governors to administer all the publicly-funded alcohol and other drug treatment and prevention programs.

Obviously you have heard much about the scope of the problem, and I do not think I can provide any greater light for you in that regard. I think a 6 million figure is significantly too low. I do not think it represents the extent of the problem. I think that most of the national alcohol organizations use the figure 10 million for alcoholics. If you add other drug abusers on top of that, that may be your 6 million, and you may be talking about a total population of more like 15 or 16 million who have problems with alcohol and other drug abuse.

But whatever it is, it is a significant problem, and I think that is really the bottom line. It is a huge problem, and it is a growing problem, and it is a problem for which we do not have adequate resources. The problem costs us about \$176 billion, which you have already pointed out, and none of that really represents the level of the human suffering and the kind of individual and human tragedies that we all deal with on a regular basis.

The Federal Office for Substance Abuse Prevention, OSAP, and you heard from Dr. Elaine Johnson this morning, and the State alcohol and drug abuse agencies in the local communities, actively involved in a number of activities ranging from prevention through intervention and treatment. Dr. Johnson referred to the demon-

stration grants and the prevention focus that they have, and I would like to say in regard to her remarks that the demonstration programs that are being funded, I think are very good and will be very useful for us. The amount of money that is available for them is not sufficient nor is the money sufficient either in State/local resources or in block grant moneys to continue and to replicate those programs at any kind of significant level.

But in addition to the prevention kinds of activities, the States and the State programs are very much involved in the treatment area.

Let me give you a very quick overview of the publicly-funded treatment system. Initially, the leadership and the administering and the monitoring of the publicly-funded programs came primarily from the Federal level. That began to shift, and then with the 1981 block grant authorization, the States were given the authority at that time to completely administer the block grants and to monitor those programs.

While the transition from the kind of categorical funding that we have experienced earlier to the block grant programs was a relatively smooth one administratively, the drastic reduction that we experienced in Federal financial support really created a great deal of problems for the States and for the local communities. In fiscal year 1980, the Federal appropriation for alcohol and other drug abuse through formula grants was \$332 million. In 1981, the first year of the block grant, it went to \$262 million, which is a 25 percent reduction right off the top. Basically, our funding—actually, we even saw further declines from fiscal year 1982 through 1986, and it wasn't until the 1986 anti-drug abuse legislation that we saw any kind of a significant increase in funding for alcohol and other drug abuse services.

And while we were in fact losing actual dollars, it is even greater than that when you take into consideration the inflation that was occurring during that same period of time.

One of the things that did happen was that the States and local communities worked very hard at trying to rally, and we did see an increase in the State and local revenues during that period of time.

Currently, the State and local funding comprises about 50 percent of the total public moneys expended on alcohol and other drug abuse, and the Federal share is about 20 percent.

Although we have many mandatory requirements for data submission, when the block grant was passed, the States were no longer mandated to provide that information. However, the State and territorial alcohol and drug abuse agencies continue to voluntarily submit a broad spectrum of fiscal and client and other service data on an annual basis. Based on some of that data regarding fiscal year 1988 expenditures and client admissions indicate that there were a total of 215,415 children and adolescents, those under the age of 21, who received or were admitted to publicly-funded programs.

Total admissions to the publicly-funded treatment programs in 1988 was 1.7 million, so the number of adolescents to that total population comprises about 13 percent of the total public admissions. And all of the data that I give you is relative to a publicly-funded system and does not include the private system.

The type and variety of treatment services that are provided by State and local communities varies greatly. In the testimony, there are a number of examples from various States in terms of what they are doing. In Missouri, we have had to divide the State into 6 regions, and we had a plan to have an adolescent program in each one of our 6 regions, a residential program with patient services. We currently have 4 of those funded. We have another one that is starting up at this point in time, and we have a sixth one that is in our fiscal year 1990 budget. But once that is completed, that gives us 120 residential beds for the entire State of Missouri. So even though we set a goal, and we are close to meeting that goal, it is barely a safety net, and it nowhere near comes close to being able to provide the level of services that are provided.

We have about 800 total publicly-funded residential beds. Right now, 80 of those are adolescents, so 1 percent of our residential beds are adolescent. We serve less than 2,000 young people annually. Again, it just does not even come close. We feel like we are doing a lot to try to move forward, and yet in terms of the magnitude of the problem, it just is not enough.

Approximately 2 years ago, NASADAD undertook a study of all State alcohol and drug abuse agencies to establish national priorities for alcohol and drug abuse services. The results of that study identified the No. 1 priority across all of the States was to develop and/or expand programs for teenagers with alcohol and other drug abuse problems. In fact, of the top 5 priorities through that survey, 4 of the 5 dealt in one way or another with concerns regarding children and youth.

In addition to that, there have been a number of other national surveys and public hearings and State task forces and advisory groups that have all indicated the same thing—there is a tremendous need.

With all of that, however, and the passage of the 1988 Anti-Drug Abuse Act, there was \$125 million in new block grant moneys. But with all of the changes that came along with that legislation, it has really created some additional problems in our being able to provide additional services to youth.

When Congress reauthorized the block grant, we had a new formula change, which changed the distribution of the funds to the States. While several of the larger States saw increases in funding, many States saw either a leveling of their services or in fact saw a decrease, and some of our States will actually lose up to 10 percent of their Federal moneys in fiscal year 1989, up to 36 percent by fiscal year 1993.

Many of the States at this point still do not know exactly what is going to happen with them, because they have the change that has already been recommended by the Senate, that the House is also looking at. So we are still not exactly sure how it is all going to play out.

But given the change in the formula and given the mandate for the IV drug abuse set-aside that half of the new moneys are spent for IV drug abuse, given the increase in the set-aside for women's services from 5 percent to 10 percent, and the creation of the revolving fund for group homes, all of those additional requirements have in fact caused many States to have to kind of put aside their

own State planning in terms of services to meet the mandates from this.

There is one other issue that I wanted to touch on. There has been a lot of attention recently in terms of the States' ability to use the Federal funds. There are several reasons for why that has been a problem in the States. One has to do with the mechanism that we draw down moneys from the Federal Government, and although we can only draw down that money 2 or 3 days ahead of time, in fact that money has been spent by the communities probably 4 to 6 months before the drawdown happens, and the commitment or the obligation of that fund has probably happened a year or so ahead of time. So there is a lapse of time between the commitment and the expenditure and the drawdown, and it in fact serves as a reimbursement mechanism for the States.

All of the States are involved in careful and deliberate planning processes in order to assure that moneys are utilized in a cost-effective manner where they are most needed. Again, given all of the new requirements of the block grant, many States have had to revamp these to meet the Federal mandates.

In addition to that, most of the States involve their State legislatures in the planning and approval process for the expenditures of these funds. This becomes a problem in many of the States and particularly in States where the legislatures only meet every 2 years. In addition to that, most States have some form of a fair, equitable, competitive procurement process that is used to select the community-based treatment providers that would receive the services.

So all of these things together impact the rate at which the States are able to draw down the Federal funds.

Senator DODD. Ms. Olson, I hate to interrupt you, but I am a little worried about the time. We are getting near 2 o'clock, and there are two witnesses following you.

Ms. OLSON. All I was going to say is there continues to be a need, and thank you for the opportunity to testify.

Senator DODD. Thank you, Ms. Olson, very much.

[The prepared statement of Ms. Olson follows:]

PREPARED STATEMENT OF LOIS OLSON

GOOD MORNING, MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE. THANK YOU FOR THE INVITATION TO APPEAR BEFORE YOU TODAY TO ADDRESS ALCOHOL AND OTHER DRUG ABUSE TREATMENT OF ADOLESCENTS.

MY NAME IS LOIS OLSON. I AM DIRECTOR OF THE DIVISION OF ALCOHOL AND DRUG ABUSE WITHIN THE MISSOURI STATE DEPARTMENT OF MENTAL HEALTH AND AM APPEARING BEFORE YOU TODAY AS THE VICE PRESIDENT FOR ALCOHOL ABUSE ISSUES FOR THE NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS (NASADAD). NASADAD IS A NOT-FOR-PROFIT ORGANIZATION WHOSE MEMBERSHIP IS COMPRISED EXCLUSIVELY OF THE STATE AND TERRITORIAL OFFICIALS DESIGNATED BY THE GOVERNORS TO ADMINISTER THE PUBLICLY FUNDED ALCOHOL AND DRUG ABUSE TREATMENT AND PREVENTION SYSTEM. THE NATIONAL ASSOCIATION'S BASIC PURPOSE IS TO FOSTER AND SUPPORT THE DEVELOPMENT OF EFFECTIVE ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND TREATMENT PROGRAMS THROUGHOUT EVERY STATE, THE DISTRICT OF COLUMBIA, PUERTO RICO AND THE U.S. TERRITORIES.

SCOPE OF THE PROBLEM

MR. CHAIRMAN, YOU AND THE MEMBERS OF YOUR SUBCOMMITTEE ARE ALREADY FAMILIAR WITH THE RANGE, COMPLEXITY AND SERIOUSNESS OF THE PROBLEMS THAT RESULT FROM ALCOHOL AND OTHER DRUG ABUSE. THESE PROBLEMS IMPACT EVERY SECTOR OF OUR SOCIETY, TRANSCENDING SOCIO-ECONOMIC LEVELS, RACE, AGE AND SEX. OVERALL, YEARLY DIRECT AND INDIRECT EXPENSES OF THESE ILLNESSES TOTAL OVER \$176 BILLION, BASED ON SUCH FACTORS AS COSTS RELATED TO REDUCED PRODUCTIVITY,

MORTALITY, TREATMENT, CRIME, MOTOR VEHICLE CRASHES AND PROPERTY LOSS. THESE STAGGERING COSTS DO NOT TAKE INTO ACCOUNT THE INDIVIDUAL AND FAMILY TRAGEDIES THAT ARISE FROM THESE PROBLEMS.

PARTICULARLY DISTRESSING IS THE IMPACT OF ALCOHOL AND OTHER DRUG ABUSE ON CHILDREN AND ADOLESCENTS AND THEIR FAMILIES. IT IS DISCOURAGING TO NOTE THAT APPROXIMATELY TWO-THIRDS OF OUR NATION'S YOUTH HAVE TRIED AN ILLEGAL DRUG BEFORE THEY GRADUATE FROM HIGH SCHOOL. WHILE THERE IS SOME EVIDENCE THAT AMONG HIGH SCHOOL SENIORS ATTITUDES ABOUT ILLEGAL DRUG USE ARE CHANGING AND THERE APPEARS TO BE SOME DECLINE IN ILLEGAL DRUG USE AMONG THIS GROUP, ALCOHOL AND OTHER DRUG ABUSE CONTINUE TO BE A MAJOR PROBLEM FOR YOUTH AT HIGH RISK, INCLUDING CHILDREN OF ALCOHOLICS, RUNAWAYS AND SCHOOL DROPOUTS.

THE FEDERAL OFFICE FOR SUBSTANCE ABUSE PREVENTION, THE STATE ALCOHOL AND DRUG ABUSE AGENCIES, AS WELL AS LOCAL COMMUNITIES ARE CONTINUING TO DEVELOP TARGETED PREVENTION PROGRAMS TO ADDRESS THE COMPLEX AND UNIQUE CHARACTERISTICS OF HIGH RISK YOUTH. IN ADDITION TO INCREASING OUR SCHOOL AND COMMUNITY PREVENTION EFFORTS, IT IS ALSO CRITICAL THAT WE ADDRESS THE INTERVENTION AND TREATMENT NEEDS OF OUR YOUTH - TO DIRECT ADDITIONAL RESOURCES AND EFFORTS TOWARD THOSE WHO ARE UNABLE TO SAY NO.

OVERVIEW OF THE PUBLICLY FUNDED TREATMENT SYSTEM

THE PUBLICLY FUNDED ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND TREATMENT NETWORK RELIES ON FINANCIAL SUPPORT FROM ALL LEVELS OF GOVERNMENT - FEDERAL, STATE AND LOCAL. THIS PARTNERSHIP EFFORT HAS EVOLVED OVER THE PAST TWO DECADES WITH THE ROLES AND RESPONSIBILITIES OF THE VARIOUS GOVERNMENTAL ENTITIES CHANGING OVER THE YEARS. THE FEDERAL GOVERNMENT'S INITIAL EFFORTS IN THE ALCOHOL AND DRUG ABUSE FIELD WERE TO PROVIDE NATIONAL LEADERSHIP AND TO STIMULATE STATE AND LOCAL GOVERNMENT PARTICIPATION IN THE DEVELOPMENT OF A WELL-COORDINATED AND COMPREHENSIVE ALCOHOL AND DRUG ABUSE SERVICE DELIVERY SYSTEM.

WITH ENCOURAGEMENT FROM THE FEDERAL GOVERNMENT, HOWEVER, THE STATES SOON ASSUMED A SIGNIFICANT PORTION OF THE RESPONSIBILITY FOR ALLOCATING AND MONITORING NOT ONLY THEIR OWN STATE REVENUES, BUT ALSO FOR AWARDING AND MONITORING FEDERAL DOLLARS TO ENTITIES WITHIN THE STATES FOR ALCOHOL AND OTHER DRUG RELATED SERVICES AND PROGRAMS THEREBY PERMITTING THE STATES TO ALLOCATE THE DOLLARS WHERE THEY WERE MOST NEEDED. WHEN THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH (ADMS) BLOCK GRANT WAS AUTHORIZED IN 1981, THE RESPONSIBILITIES OF THE FEDERAL GOVERNMENT FOR THE ADMINISTRATION OF THE FEDERAL ALCOHOL AND DRUG ABUSE SERVICES PROGRAMS WERE EASED SIGNIFICANTLY. THE ADMS BLOCK GRANT, AUTHORIZED BY P.L. 97-35, TURNED COMPLETE ADMINISTRATIVE RESPONSIBILITY FOR THE

FEDERAL ALCOHOL AND OTHER DRUG ABUSE SERVICES DOLLARS OVER TO THE STATES. ALREADY RESPONSIBLE FOR ADMINISTERING THREE-FOURTHS OF THE FEDERAL ALCOHOL AND DRUG ABUSE PROGRAMS THROUGH A MECHANISM SIMILAR TO THE ADMS BLOCK GRANT, THE STATES WERE WELL PREPARED AND WILLING TO ACCEPT RESPONSIBILITY FOR AWARDING AND MONITORING THE SERVICE DOLLARS INCLUDED IN THE ADMS BLOCK GRANT PROGRAM.

WHILE THE TRANSITION FROM CATEGORICAL GRANTS TO BLOCK GRANTS PROVED TO BE A SMOOTH ONE FROM AN ADMINISTRATIVE STANDPOINT, THE MOVE HAMPERED STATES' ABILITIES TO PROVIDE INCREASED ALCOHOL AND OTHER DRUG ABUSE TREATMENT SERVICES TO THOSE IN NEED BECAUSE OF THE DRASTIC REDUCTION IN FEDERAL FINANCIAL SUPPORT THAT ACCOMPANIED THE CREATION OF THE ADMS BLOCK GRANT PROGRAM. IN FY 1980, FEDERAL APPROPRIATIONS FOR THE ALCOHOL AND DRUG ABUSE PROJECT AND FORMULA GRANT PROGRAMS TOTALED \$332 MILLION. IN FY 1981, THE FIRST YEAR OF FUNDING FOR THE NEW ADMS BLOCK GRANT, THE ALCOHOL AND DRUG ABUSE PORTION OF THE BLOCK GRANT WAS \$262.8 MILLION - A 25 PERCENT REDUCTION FROM FY 1980 LEVELS WITHOUT ADJUSTING FOR INFLATION. AND IN FISCAL YEARS 1982 THROUGH 1986, FURTHER REDUCTIONS IN THE BLOCK GRANT APPROPRIATIONS OCCURRED EACH YEAR. IT WAS NOT UNTIL THE PASSAGE OF THE 1986 ANTI-DRUG ABUSE ACT (P.L. 99-570) AND THE CREATION OF A NEW ALCOHOL AND DRUG ABUSE TREATMENT BLOCK GRANT THAT INCREASES IN FEDERAL DOLLARS FOR ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND TREATMENT SERVICES WERE PROVIDED.

ONE ENCOURAGING NOTE IS THAT DURING THE SAME PERIOD THAT FEDERAL FUNDING FOR ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND TREATMENT SERVICES WAS CUT, THE STATES AND LOCAL GOVERNMENTS INCREASED THEIR FINANCIAL SUPPORT SIGNIFICANTLY. CURRENTLY, STATE AND LOCAL FUNDING COMPRISES ABOUT 50 PERCENT OF THE TOTAL EXPENDED FOR PUBLIC ALCOHOL AND OTHER DRUG ABUSE TREATMENT AND PREVENTION SERVICES; THE FEDERAL SHARE IS ABOUT 20 PERCENT. THE REMAINDER OF SUPPORT COMES FROM THIRD-PARTY REIMBURSEMENT, CLIENT FEES AND OTHER SOURCES.

ACCOMPANYING THE CREATION OF THE ADMS BLOCK GRANT WAS THE ELIMINATION OF MANDATORY DATA REPORTING REQUIREMENTS WHICH HAD PROVIDED A COMPREHENSIVE NATIONAL PICTURE OF THE TREATMENT AND PREVENTION NETWORK AND ITS CLIENTS. BY 1984, THE NEED FOR GOOD NATIONAL INFORMATION WAS RECOGNIZED AND NASADAD ENTERED INTO AN AGREEMENT WITH THE NATIONAL INSTITUTE OF ALCOHOLISM AND ALCOHOL ABUSE AND THE NATIONAL INSTITUTE OF DRUG ABUSE TO COLLECT INFORMATION ON EXPENDITURES AND CLIENT ADMISSIONS. THE STATE AND TERRITORIAL ALCOHOL AND DRUG ABUSE AGENCIES CONTINUE TO VOLUNTARILY SUBMIT A BROAD SPECTRUM OF FISCAL, CLIENT AND OTHER SERVICES DATA ON AN ANNUAL BASIS TO NASADAD.

PRELIMINARY DATA FROM THE MOST RECENT SURVEY, THE STATE ALCOHOL AND DRUG ABUSE PROFILE (SADAP), REGARDING FISCAL 1988 EXPENDITURES AND CLIENT ADMISSIONS INDICATE THAT A TOTAL OF

215,415 CHILDREN AND ADOLESCENTS WERE ADMITTED TO PUBLICLY FUNDED ALCOHOL AND OTHER DRUG ABUSE TREATMENT PROGRAMS. SPECIFICALLY, THERE WERE 46,985 CHILDREN AND ADOLESCENTS UNDER AGE 18 ADMITTED TO TREATMENT NATIONWIDE WITH ALCOHOL AS THEIR PRIMARY DRUG OF ABUSE AND 55,835 YOUNG ADULTS AGED 18 TO 20 ADMITTED FOR PRIMARY ALCOHOL ABUSE. REGARDING OTHER DRUGS OF ABUSE, 75,841 CHILDREN AND ADOLESCENTS UNDER AGE 18 WERE ADMITTED TO TREATMENT NATIONWIDE AND 36,754 AGED 18 TO 20.

TOTAL ADMISSIONS TO TREATMENT IN PUBLICLY FUNDED PROGRAMS IN FY 1988 WERE OVER 1.7 MILLION, INCLUDING 1.2 MILLION ADMISSIONS FOR PRIMARY ALCOHOL ABUSE AND 517,000 ADMISSIONS FOR OTHER DRUGS. THUS, IN FY 1988 ADOLESCENTS COMPRISED APPROXIMATELY 13 PERCENT OF TOTAL ADMISSIONS TO THE PUBLICLY FUNDED ALCOHOL AND OTHER DRUG ABUSE TREATMENT SYSTEM.

TREATMENT SERVICES PROVIDED TO ADOLESCENTS

THE TYPE AND VARIETY OF TREATMENT SERVICES PROVIDED BY THE STATES AND LOCAL COMMUNITIES TO CHILDREN AND ADOLESCENTS VARY ACCORDING TO STATE DETERMINED NEEDS AND TO AVAILABILITY OF SPECIFIC FUNDING FOR THESE SERVICES. BY WAY OF EXAMPLE, I WOULD LIKE TO HIGHLIGHT THE EXPERIENCES OF SEVERAL STATES IN DESIGNING AND IMPLEMENTING TREATMENT SERVICES FOR YOUTH.

WASHINGTON

THE STATE'S BUREAU OF ALCOHOL AND SUBSTANCE ABUSE, IN PARTNERSHIP WITH COUNTIES AND PRIVATE AGENCIES, PROVIDES PREVENTION, EARLY INTERVENTION AND DIRECT TREATMENT SERVICES TO INDIVIDUALS AND THEIR FAMILIES, INCLUDING CHILDREN AND ADOLESCENTS. THE DIVISION OF JUVENILE REHABILITATION ALSO PROVIDES A FULL RANGE OF ALCOHOL AND OTHER DRUG SERVICES TO JUVENILE OFFENDERS WITHIN ITS JURISDICTION. FOR EXAMPLE, THE EXODUS PROGRAM IS THE FIRST INPATIENT SUBSTANCE ABUSE FACILITY IN THE COUNTRY TO BE LOCATED ON THE CAMPUS OF A JUVENILE JUSTICE INSTITUTION. ON THE SITE IS A 60-DAY, 16 BED STATE CERTIFIED CHEMICAL DEPENDENCY TREATMENT UNIT. OTHER STATES HAVE USED THE EXODUS PROGRAM AS A MODEL FOR THEIR JUVENILE JUSTICE TREATMENT PROGRAMS.

INADEQUATE RESOURCES MAKE IT IMPOSSIBLE TO SERVE MORE THAN 10 PERCENT OF THE ESTIMATED 80,000 CHILDREN AND ADOLESCENTS IN WASHINGTON WITH SERIOUS ALCOHOL AND OTHER DRUG ABUSE PROBLEMS. THERE ARE ONLY 33 PUBLICLY FUNDED INTENSIVE INPATIENT TREATMENT BEDS FOR ADOLESCENTS IN THE ENTIRE STATE.

THE STATE OF WASHINGTON'S LEGISLATURE IS CURRENTLY CONSIDERING AN OMNIBUS DRUG BILL WHICH WOULD PROVIDE \$12 MILLION IN NEW MONEY FOR A FULL ARRAY OF ADOLESCENT TREATMENT SERVICES, INCLUDING INPATIENT, OUTPATIENT AND AFTERCARE. THE DRUG BILL WOULD ALSO FACILITATE THE LINKING OF ALCOHOL AND DRUG ABUSE TREATMENT WITH

OTHER CHILDREN'S SERVICES TO MORE APPROPRIATELY IDENTIFY AND TARGET RESOURCES TO THOSE YOUTH AT HIGH RISK.

UTAH

FOR THIS YEAR, UTAH PLANS TO SPEND \$1.1 MILLION OF THE STATE'S TOTAL BLOCK GRANT FUNDS OF \$5.7 MILLION FOR TREATMENT SERVICES TO YOUTH. LAST YEAR, 1,471 ADOLESCENTS WERE ADMITTED TO TREATMENT-4.5 PERCENT OF THE STATE'S TOTAL ADMISSIONS TO PUBLIC PROGRAMS. THREE-FOURTHS OF THE SERVICES PROVIDED TO YOUTH WERE OUTPATIENT PROGRAMS. THIS YEAR, THE STATE ANTICIPATES INCREASING ADMISSIONS TO 1,700. UTAH ESTIMATES THAT THERE ARE BETWEEN 15,000 AND 20,000 YOUTH IN NEED OF TREATMENT IN THE STATE. SIXTY-FIVE (65) PERCENT OF ADOLESCENTS ARE ADMITTED TO TREATMENT WITH ALCOHOL AS THEIR PRIMARY DRUG OF ABUSE; 22 PERCENT FOR ABUSE OF MARIJUANA; 5 PERCENT FOR COCAINE ABUSE, AND 8 PERCENT FOR ALL OTHER DRUGS. THE STATE IS BEGINNING TO EXPERIENCE LOS ANGELES GANG ACTIVITY RELATED TO DEVELOPING MARKETS FOR CRACK COCAINE AND EXPECTS TO SEE A RISE IN ADMISSIONS FOR CRACK COCAINE ABUSE IN FUTURE YEARS.

IOWA

IN DECEMBER 1986, A TASK FORCE ON JUVENILE SUBSTANCE ABUSE TREATMENT SERVICES ISSUED A REPORT ASSESSING CURRENT SERVICES AND RECOMMENDED CHANGES IN THE SERVICE DELIVERY SYSTEM. THE TASK FORCE ESTIMATED THAT BETWEEN 26,000 AND 27,000 ADOLESCENTS IN THE

STATE NEED SOME FORM OF SUBSTANCE ABUSE TREATMENT.

THE TASK FORCE RECOMMENDED THAT \$1.5 MILLION IN ADDITIONAL FUNDING BE PROVIDED BY JULY 1, 1990 TO FUND JUVENILE-SPECIFIC ALCOHOL AND OTHER DRUG ABUSE TREATMENT SERVICES, INCLUDING INTERVENTION, ASSESSMENT, TREATMENT AND AFTERCARE PROGRAMS. THE TASK FORCE FURTHER RECOMMENDED THAT FUNDING BE PROVIDED TO ENHANCE EFFORTS TO IDENTIFY, REFER AND TREAT MINORITY AND FEMALE CHEMICALLY DEPENDENT ADOLESCENTS.

LAST YEAR, 8 PERCENT OF THE CLIENTS IN IOWA'S PUBLICLY FUNDED TREATMENT PROGRAMS WERE JUVENILES - APPROXIMATELY 2,000. FOR BOTH ADOLESCENTS AND ADULTS, ALCOHOL IS THE PRIMARY ABUSED DRUG IN IOWA; MARIJUANA THE SECOND.

REGARDING SPECIFIC TYPES OF TREATMENT SERVICES, THERE ARE SIX PUBLICLY FUNDED RESIDENTIAL FACILITIES WITH A TOTAL OF 127 BEDS SERVING ADOLESCENTS. TWO IOWA STATE JUVENILE FACILITIES INCLUDE ALCOHOLICS ANONYMOUS AND COUNSELING GROUPS. PROGRAMS AT BOTH THE IOWA JUVENILE HOME AND THE STATE TRAINING SCHOOL INCLUDE ONE-TO-ONE COUNSELING AND SPECIAL GROUPS FOCUSING ON RELAPSE PREVENTION, PERSONAL AWARENESS, AFTER CARE, CHILDREN OF ALCOHOLICS AND WOMEN'S ISSUES.

SIGNIFICANT CHANGES IN ADOLESCENT TREATMENT IN OTHER STATES INCLUDE THE FOLLOWING:

- ALASKA - FEDERAL FUNDING THROUGH THE INDIAN HEALTH SERVICE HAS ESTABLISHED TWO NEW YOUTH RESIDENTIAL TREATMENT PROGRAMS;
- ARKANSAS - A SPECIALIZED TREATMENT SERVICES PILOT PROGRAM WAS INITIATED IN ONE LOCATION;
- CONNECTICUT - RESIDENTIAL TREATMENT SERVICES TO THE UNDER 18 POPULATION WERE TRANSFERRED TO THE DEPARTMENT OF CHILD AND YOUTH SERVICES AS PART OF A LONG RANGE PLAN TO COORDINATE ALL SERVICES FOR CHILDREN;
- HAWAII - WITH FEDERAL FUNDS, THE STATE HAS ATTEMPTED TO LINK ADOLESCENT OUTPATIENT INTERVENTION AND TREATMENT SERVICES TO VARIOUS DEPARTMENT OF EDUCATION COMPLEXES;
- INDIANA - THE STATE HAS JUST OPENED ITS FIFTH PUBLIC RESIDENTIAL ADOLESCENT TREATMENT CENTER AND NOW HAS TWO-THIRDS OF THE BEDS THEY HAVE IDENTIFIED AS NECESSARY FOR LOW INCOME FAMILIES. THESE FACILITIES ARE SUPPORTED 60 PERCENT BY THE WELFARE DEPARTMENT AND 40 PERCENT BY THE STATE ALCOHOL AND DRUG ABUSE AGENCY.
- KANSAS - A SECOND YOUTH RESIDENTIAL TREATMENT CENTER WAS OPENED TO SERVE INDIGENT YOUTH;
- MARYLAND - LAST YEAR, THERE WERE 4,096 ADOLESCENTS ADMITTED TO ALCOHOL AND OTHER DRUG ABUSE TREATMENT PROGRAMS, WHICH REPRESENTS A 77 PERCENT INCREASE IN ADOLESCENT ADMISSIONS SINCE FY 1983. RESIDENTIAL CARE WAS INCREASED WITH THE ADDITION OF 10 NEW INTERMEDIATE

CARE BEDS AND 27 GROUP HOME BEDS;

- o MONTANA - A NEW 20 BED ADOLESCENT TREATMENT FACILITY OPENED LAST YEAR;
- o VERMONT - LAST YEAR, THE STATE OPENED AN 18 BED SUBSTANCE TREATMENT CENTER FOR YOUTH.

CONTINUING NEED FOR EXPANDED ADOLESCENT TREATMENT SERVICES

ACROSS OUR NATION DRUG ABUSE AND ALCOHOL PROBLEMS CONTINUE TO GROW IN MAGNITUDE AND SEVERITY, PARTICULARLY AMONG OUR YOUTH. STATES AND LOCAL COMMUNITIES THROUGHOUT THE COUNTRY HAVE A SIGNIFICANT AND GROWING NEED FOR ADDITIONAL FEDERAL APPROPRIATIONS FOR ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND TREATMENT SERVICES.

APPROXIMATELY TWO YEARS AGO, NASADAD UNDERTOOK A STUDY OF ALL STATE ALCOHOL AND DRUG ABUSE AGENCIES TO ESTABLISH NATIONAL PRIORITIES FOR ALCOHOL AND OTHER DRUG ABUSE SERVICES. IT WAS ANTICIPATED THAT THE LIST OF PRIORITIZED POLICY ISSUES WOULD BE OF ASSISTANCE IN SHORT AND LONG-TERM PLANNING FOR DIFFERENT STATE SERVICE SYSTEMS AND PERHAPS GUIDE BOTH THE FEDERAL AND STATE RESOURCE ALLOCATION EFFORTS.

THE RESULTS OF THE STUDY IDENTIFIED THE NUMBER ONE PRIORITY AS "DEVELOP AND/OR EXPAND PROGRAMS FOR TEENAGERS WITH ALCOHOL AND

DRUG ABUSE PROBLEMS." IN FACT, FOUR OF THE TOP FIVE PRIORITIES CONCERNED SERVICES FOR CHILDREN AND YOUTH.

IN ADDITION TO THIS NATIONAL SURVEY, PUBLIC HEARINGS, STATE TASK FORCES AND ADVISORY COUNCILS IN MOST STATES HIGHLIGHT THE CONTINUING NEED TO PROVIDE INCREASED SERVICES TO ADOLESCENTS. AS THE PREVIOUS STATE EXAMPLES INDICATE, MANY STATES ARE WORKING TOWARD THAT GOAL.

THE RECENTLY PASSED 1988 ANTI-DRUG ABUSE ACT (P.L. 100-690) INCLUDED \$125 MILLION IN NEW FEDERAL BLOCK GRANT DOLLARS TARGETED TO ALCOHOL AND OTHER DRUG ABUSE TREATMENT. HOWEVER, A NUMBER OF CHANGES WERE INCLUDED IN THE LEGISLATION WHICH WILL SIGNIFICANTLY IMPACT THE DELIVERY OF ADDITIONAL SERVICES TO YOUTH.

WHEN CONGRESS REAUTHORIZED THE ADMS BLOCK GRANT LAST OCTOBER, A NEW ALLOCATION FORMULA WAS ADDED WHICH CHANGED THE DISTRIBUTION OF FUNDS AMONG THE STATES. WHILE SEVERAL LARGE, MORE URBAN STATES SAW FUNDING INCREASES, MANY STATES DISCOVERED THAT THEY WOULD ONLY RECEIVE LEVEL FUNDING OR IN SOME CASES, ACTUALLY LOSE MONEY. ADDITIONALLY, STATES STILL AREN'T CERTAIN OF THEIR FY 1989 ALLOCATIONS BECAUSE THE TECHNICAL CORRECTIONS BILL RECENTLY PASSED IN THE SENATE WOULD CHANGE THE FORMULA ONCE AGAIN.

THIS UNCERTAINTY, COUPLED WITH OTHER CHANGES IN THE BLOCK GRANT

PROGRAM IMPACT NEGATIVELY ON STATES' ABILITIES TO PLAN AND TARGET FUNDS TO AREAS OF GREATEST NEED. PRIOR TO THE PASSAGE OF P.L. 100-690, MANY STATES HAD INTENDED TO TARGET FEDERAL MONIES TO EXPANDING ADOLESCENT TREATMENT SERVICES. HOWEVER, TO MEET THE NEW IV DRUG ABUSE MANDATE, THE INCREASING OF THE WOMEN'S SET-ASIDE FROM 5 TO 10 PERCENT, AND THE CREATION OF A REVOLVING LOAN FUND FOR GROUP HOMES, MANY STATES' PLANS FOR INCREASING ADOLESCENT SERVICES HAD TO BE SCUTTLED.

FACTORS INFLUENCING THE STATES' USE OF ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT FUNDS

THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT MONIES ARE AVAILABLE TO STATES ON A "DRAW DOWN" BASIS THAT PERMITS FUNDS TO BE TAKEN FROM THE FEDERAL TREASURY A MAXIMUM OF ONLY TWO OR THREE DAYS BEFORE A STATE WRITES CHECKS TO REIMBURSE COMMUNITY PROGRAMS FOR SERVICES; ONLY AT THIS TIME DOES THE COMMUNITY PROGRAM EXPENDITURE SHOW UP AS A DRAW DOWN; IN FACT, THE FUNDS HAVE BEEN ACTUALLY SPENT BY COMMUNITY AGENCIES AS LONG AS SEVERAL (THREE TO FOUR) MONTHS BEFORE THE FEDERAL MONEY IS DRAWN DOWN AND HAVE BEEN LEGALLY OBLIGATED BY THE STATE AS LONG AS 12 MONTHS PRIOR TO THE DRAW DOWN. THUS, FOR STATES, THE ADMS BLOCK GRANT OPERATES PRIMARILY AS A REIMBURSEMENT MECHANISM.

AS PROVIDED FOR WITHIN THE 1988 DRUG BILL, THE BLOCK GRANT AWARD

NOTICE SENT BY THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION (ADAMHA) TO THE STATES INDICATED THAT THE MONIES WERE AVAILABLE FOR OBLIGATION UNTIL SEPTEMBER 30, 1989 AND FOR EXPENDITURE (DRAW DOWN) UNTIL SEPTEMBER 30, 1990. IT IS UNREALISTIC TO EXPECT STATES TO HAVE DRAWN DOWN THE MAJORITY OF FY 1989 FUNDS AT THIS POINT IN TIME. ONLY SEVEN MONTH INTO A 24 MONTH EXPENDITURE PERIOD.

SINCE THE ADMS BLOCK GRANT PROGRAM IS NOW INSTITUTIONALIZED WITHIN BOTH THE FEDERAL AND STATE PLANNING PROCESSES, ESTABLISHED PROCEDURES INCLUDING THE CONGRESSIONALLY MANDATED STATE PUBLIC HEARINGS ON THE PROPOSED USE AND DISTRIBUTION OF BLOCK GRANT MONIES HAVE BEEN INCORPORATED INTO STATES' LEGISLATIVE AND ADMINISTRATIVE SCHEDULES.

MANY EXISTING TREATMENT FACILITIES DO NOT HAVE THE PHYSICAL ROOM TO EXPAND. THE 1988 DRUG ACT PROVIDED THAT THE HHS SECRETARY MAY GRANT A WAIVER TO STATES TO PERMIT FACILITY RENOVATION AND CONSTRUCTION. ADAMHA HAS NOT YET ISSUED THE GUIDELINES TO STATES INDICATING HOW STATES MAY APPLY FOR THIS WAIVER. A NUMBER OF STATES ARE WAITING FOR THE ISSUANCE OF THESE GUIDELINES AND WAIVERS SO THAT THEY WILL KNOW WHETHER OR NOT THEY CAN EXPEND MONIES ON DESPERATELY NEEDED FACILITIES.

ALL STATES IMPLEMENT A CAREFUL AND DELIBERATE PLANNING PROCESS IN

ORDER TO ENSURE THAT MONIES ARE UTILIZED IN A COST EFFECTIVE MANNER WHERE THEY ARE MOST NEEDED - IN MANY STATES THIS PROCESS INVOLVES THE STATE LEGISLATURE'S REVIEW AND APPROVAL OF THE ALLOCATION OF THESE IMPORTANT RESOURCES. ALSO, IN A FEW STATES THE LEGISLATURE MEETS ONLY ONCE EVERY TWO YEARS. FINALLY, IN MOST STATES A FAIR AND EQUITABLE COMPETITIVE PROCUREMENT PROCESS IS USED TO SELECT COMMUNITY BASED TREATMENT PROVIDERS.

CONCLUSION

WHILE THERE CONTINUES TO BE A GREAT NEED FOR INCREASED ALCOHOL AND OTHER DRUG ABUSE SERVICES TO CHILDREN AND ADOLESCENTS, STATES AND LOCAL COMMUNITIES ARE STRIVING TO MAKE ADDITIONAL TREATMENT SERVICES A REALITY. MR. CHAIRMAN, THE MEMBERS OF NASADAD COMMEND YOU FOR YOUR INTEREST IN EXPLORING ADOLESCENT SUBSTANCE ABUSE TREATMENT ISSUES AND OFFER OUR ASSISTANCE TO YOU AS FURTHER CONSIDERATION AND POSSIBLE SOLUTIONS TO THE PROBLEM ARE DISCUSSED.

WITH CONTINUED FEDERAL LEADERSHIP AND RESOURCES, THE STATES AND LOCAL COMMUNITIES STAND READY TO MEET THE CHALLENGE OF PROVIDING COMPREHENSIVE QUALITY TREATMENT AND REHABILITATION SERVICES TO OUR YOUTH.

Senator DODD. Dr. Wurmser.

Dr. WURMSER. Thank you, Senator.

I am Jeanne Wurmser, and I am executive director of CPC Mental Health Services in Eatontown, NJ.

My agency is a nonprofit human service corporation which provides mental health, chemical dependency special education, residential treatment, foster care, and consultation and training services to adults, children and adolescents.

I am in a different position than many of the people who have presented to you. The clients are on my doorstep, and I am at the bottom of the paperwork chute.

I want to talk a little bit about some of the systems issues and some of the barriers to treatment that we struggle with in a community agency on a day-to-day basis.

I agree with the points that you made earlier that adolescents are at a truly vulnerable point in their physical, emotional and behavioral development. There is a window of opportunity at which we must intervene if we are going to make a difference in these children's lives.

My agency has tried very hard to work with other community agencies as Federal funds were decreased. We started off as a Federal community mental health center and included drug and alcohol abuse services to adults and adolescents as part of our coordinated services. We had a real commitment that a family ought not to get caught up in conflicts between different kinds of agencies, and that we ought to be their advocate, we ought to identify what their service needs were and make sure that they had access to the range of services that they needed.

We worked with the courts and the juvenile courts, and it became very clear that in addition to evaluations for mental health problems that many of the clients needed evaluation of substance abuse problems and needed treatment for substance abuse problems.

We also discovered as we dealt with foster care, with the court system, with children who went in and out of State psychiatric facilities, that about 60 percent of them came from families in which there was a substance-abusing person—either one of the adult members of the family or one of the child members of the family.

So we became very clear that focusing on substance services had to go throughout all of our other programs. When we deal with chronically mentally ill young adults, we find that 60 percent of them are seriously involved in substance abuse, which obviously interferes with our ability to rehabilitate them and to deal with their psychiatric illness.

We have tried to work in a partnership with the schools and the other agencies that serve youth in our community. We have developed student assistance programs, and we have identified a number of groups that we think must be identified at an early stage. These included those high-risk youth with addicted or abusing parents, those who have been physically or sexually abused in their own lives—we are finding that in later life, there is a very high incidence of substance abuse among these children—those who are failing to achieve in school, those who are socially isolated, and those,

as other people have mentioned, who have already begun a pattern of delinquent or violent behavior.

We find that again, as many other people have stated, the programs have to aim earlier. We are seeing a lot of 14- and 15-year-olds in our outpatient services who began using drugs and alcohol at age 10 or 11. So prevention services clearly have to be pitched to those first 4 and 5 years in school and even to preschool programs in terms of helping children to see how to deal with their feelings in appropriate ways and to give children appropriate coping mechanisms.

As I said, programs need to change to meet the changing needs of their communities, and as a community mental health center we made a commitment to try to assess the needs and to change our services as the needs change. We feel that it is critical that we decrease the fragmentation of services at the community level to avoid providing frustration to families who are desperately seeking help.

We really need to work through this at all levels of the system.

I would like to talk a little bit about some of the barriers and service problems that we deal with. The first is waiting lists. I am funded for about 58 slots for adults and adolescents; at any time, I have a waiting list of 40 to 70 people who have indicated that they are ready to begin treatment, and it is a tremendous frustration not to be able to provide treatment to those people when they need it.

In addition, I deal with constant turnover, because we are funded at such a low level that we cannot pay adequate salaries to professional staff, and we are constantly—I am in the New York Metropolitan area, so there is a tremendous amount of competition for trained professionals, and I am constantly losing staff to private for-profit agencies, and even to State agencies which can pay a higher rate than they fund the local community agencies to pay.

We are finding that there is a tremendous need for special programs for dually-diagnosed children and adolescents, those who have a serious emotional disturbance and who have also become involved in substance abuse. They need staff with special training and special efforts.

As I said, we need access to substance abuse services for youth in all parts of our system—our services for the chronically mentally ill, our services in the corrections system, our young people who are in foster care. We need to identify their problems at a much earlier stage.

We need much better funding for indigent clients. The slots that are funded to us are funded on the assumption that we are going to make up a large part of the cost through fees and third-party payments—and for indigent clients, that is obviously not the case, and the agency struggles at trying to find the money to fill in the deficit that the State funding does not cover. There is a tremendous dearth of residential programs for indigents, for people who do not have insurance or do not have the money to pay for the service.

Finally, you heard a great deal about short-term family-oriented programs and intensive long-term residential treatment programs, which have both proved their effectiveness. In addition, we feel that there is a program in the middle that State agencies have not

planned for and do not fund actively and that we need to develop further. That is a program called intensive outpatient programs.

In many cases, if you take an adolescent out of school, send them away to a hospital or a residential program for a 28- or 30-day stay, they may stop using. They may react to the different peer culture, they may react positively to new role models, and they may make a change in their behavior. But when you bring them right back to the same school, to the same peer group, to the same family situations, to the same financial stresses that may have been causing problems in the family before, there is a tremendous difficulty in their maintaining their sobriety and their drug-free behavior.

We feel that it can be extremely cost-effective for adolescents to have an intensive evening program for a period of about 12 weeks in which there is 5-night-a-week and weekend services. One of the things that adolescents need to do is find more constructive ways to fill their leisure time, and so structured recreation is a key part of this.

Unfortunately, Medicaid does not have reimbursement for intensive outpatient even though it is much cheaper than a 30-day stay in a hospital program in which, in many cases, you are going to have relapse. So we feel there is a tremendous need to fund community agencies, to provide these intensive programs, to keep kids and help them learn new coping skills in the system. If you are going to deal with the family, you obviously have a much better chance of doing that if you are keeping them at home.

We need to work with schools, and schools need to change to support a much more holistic health approach for youth who are trying to change their lifestyles to give up drug or alcohol dependency. Most of these kids have dropped out of sports; they are not in the school activities. They are not doing things with peers to make them feel good about themselves. And schools have the physical grants and in many cases the dedicated staff to help us provide new activities and new services and new programs for children who are coming back from inpatient or residential care or who are in an intensive outpatient program. And we feel that we could use school facilities to provide a lot of very excellent structured recreation and other programs to help support new behaviors and new lifestyle changes.

Schools can play a critical role in identifying youth and families with problems at a very early stage and linking them to services, and States and the Federal Government need to provide incentives for school systems which are funded through a totally different mechanism than the community treatment agencies to coordinate with treatment agencies and vice versa.

Finally, again, from my view at the bottom of the paperwork chute, there is sometimes tremendously poor coordination of State, county, Federal planning, funding and monitoring activities. My agency gets funded by 8 different parts of the State and 6 different parts of the county. I have to deal with duplicate of reports, separate applications, different fiscal years, overlapping site visits. These are all resources that I have to put into trying to get the dollars that I could divert to planning better programs and supervising my clinical staff, and I would much rather do that. So we certainly request your assistance in trying to urge coordination of

services and reducing the duplication in terms of some of these planning functions.

Finally, many private nonprofit agencies have a need for a bonding authority to develop capital funds. Many of our agencies are tremendously undercapitalized, and we need to improve facilities and to increase our facilities in order to serve more clients.

I think the largest barrier for families is the fragmentation of the service systems at the community level, and we must address this. Youth who need help pass through shelters, they pass through police stations, they pass through hospitals and pediatricians' offices and many other community settings, and we need to find a way to identify those who need substance abuse evaluation and treatment and provide help in that narrow window of opportunity which is adolescence.

Thank you.

Senator DODD. Thank you very much.

[The prepared statement of Dr. Wurmser follows:]

PREPARED STATEMENT OF DR. JEANNE H. WURMSER

Good morning Mr. Chairman, I am Jeanne H. Wurmser, Ph.D. Executive Director of CPC Mental Health Services, Inc. in Eatontown, New Jersey. CPC Mental Health Services is a human service corporation providing mental health, chemical dependency special education, residential treatment, foster care, consultation and training services. In my position as Executive Director, I am responsible for clinical and administrative management of a \$10 million budget and a staff of over 200.

I am grateful for the opportunity to offer testimony to the Subcommittee on the topic of access to substance abuse treatment services for adolescents. The opening paragraph of CPC's Mission Statement reads as follows:

CPC Mental Health Services, Inc. is a non-profit corporation organized to provide high quality human services aimed at maximizing the adjustment of persons suffering from emotional or behavioral disorders, chemical dependency, developmental or learning disabilities or the effects of stress or trauma. The corporation also seeks to provide educational and prevention programs aimed at preventing disorders, disabilities or behavioral problems in residents of our community.

Mr. Chairman, I read to you this Mission Statement in order to make the point that the focus at the community agency level is to allocate resources to the current problems facing the citizens of its community. We need to change our programs to meet changing needs. Our efforts are often frustrated by the difficulty federal, state and local bureaucracies have in changing their

health and human service planning, funding and monitoring functions.

We are a private, non-profit community agency with a commitment to providing coordinated and professional health services to our clients. CPC Mental Health Services, Inc. was founded to serve the mental health and counseling needs of children and their families. We added services to meet community needs. We integrated these into a comprehensive community mental health center in the 1970s and then were forced to cut back on prevention and outreach services as block grants were given over to the states. We find that states have set priorities and constraints which do not value coordinated service planning or continuity of care.

We believe that adolescents are at a very vulnerable point in their physical, emotional and behavioral development. There is a great risk that adolescents who begin using drugs may be developing a permanent coping mechanism.

Intensive prevention efforts should be aimed at high-risk youth:

- o those with addicted or substance abusing parents;
- o those who have been physically or sexually abused;
- o those failing to achieve in school;
- o those who are socially isolated;
- o those beginning a pattern of delinquent or violent behavior.

Our children are being exposed to drugs earlier--in the community and in their homes. We are seeing 14 and 15 year olds who began using drugs or alcohol or both at 10 or 11. We are seeing youth from families at all socioeconomic levels become involved in selling drugs. Adolescents who are abusing drugs are usually involved in other destructive behavioral patterns. In order to intervene effectively--to make real changes in their lives and behavior--agencies providing substance abuse evaluation and treatment must also have access to mental health evaluation and treatment resources. A teenager who is abusing drugs and/or alcohol but who is having repeated suicidal thoughts cannot be partitioned into two neatly separated parts for evaluation and treatment. Many of these youngsters are also seen in the Family Court. Service plans which are developed by the court must have access to coordinated systems of service. Treatment agencies often need the leverage of the court to encourage youth and their families who are denying their difficulties to enter treatment programs.

Mr. Chairman, we attempt to provide outreach, education, prevention and early identification programs in the schools to work with these key community institutions to reduce the demand for drugs and the incidence of addiction and abuse by adolescents. We try to provide treatment which meets the multiple needs of troubled adolescents and dysfunctional families.

BARRIERS AND SERVICE SYSTEM PROBLEMS

Our efforts to prevent and treat adolescent substance abuse are frustrated by a number of problems. Some, but not all, will require additional public and

private resources to address.

Waiting Lists: Most community agencies have long waiting lists for treatment. Competition between private, for-profit and public or non-profit agencies for trained professional staff is intense. We routinely lose well-qualified staff to private practice, for-profit corporations or to state agencies which pay higher salaries than we are funded to offer. Excessive turnover disrupts treatment, causes delays in initiating treatment and saps the energy of dedicated staff who remain. I should add that in New Jersey and many other states, non-profit community agencies have no bond authority or other means of financing capital construction. Additional resources would allow us not only to upgrade compensation for our staff, but also provide us with an opportunity to increase the number of treatment slots available for adolescents.

Special Programs for Dually-Diagnosed Adolescents: Adolescents who are abusing drugs or alcohol but also suffer from emotional, cognitive or behavior disorders need treatment by professional staff with expertise in mental health as well as substance abuse. Almost no residential programs are available for the mentally ill substance abuser and few outpatient programs provide coordinated treatment. Our center sees increasing numbers of adolescents who are suicidal, psychotic or otherwise dangerous to themselves or others. In New Jersey, substance abuse programs are managed by the Department of Health while community mental health programs are managed by the Department of Human Services. There is, from our view at the bottom of the paperwork chute, no coordination between these departments around their planning, funding and monitoring roles as they impact community agencies. There are formalized

routes for input regarding certificates of need for inpatient beds in hospitals and Medicaid reimbursement but even these areas of communication are problematic. State run psychiatric hospitals for adolescents do not have well developed programs for dually-diagnosed adolescents. Youth in the correction system and Family Court do not have access to much needed programs for dually-diagnosed youth. A smaller but high need population is of those who are developmentally disabled but also have developed substance abuse problems as adolescents and young adults.

Funding of Services For Indigent Clients: Our state system and national program for funding substance abuse does not provide adequate funding for services to indigent clients. Residential treatment beds for indigent adolescents are all but nonexistent. Outpatient funding systems follow a model which funds outpatient "slots" at less than the full cost of providing such services. The assumption that the difference can be made up through sliding scale fees, Medicaid and insurance payments turns out to be invalid. Many clients do not cooperate in paying even minimal fees while they are still at the stage of denying that they have a substance abuse problem. Medicaid and insurance do not reimburse for urine testing. The State's Medicaid rate for outpatient counseling is only a fraction of the cost per unit to deliver the service.

Intensive Outpatient Programs: We believe that intensive outpatient programs are a more effective way to treat adolescent substance abusers than residential treatment in the majority of cases. An adolescent who is pulled out of school may do well in a 28 day residential program which provides a healthier peer culture and healthy adult role models. At the end of the

residential stay, he/she must return abruptly to the school and family setting in which his/her dysfunctional attitudes, beliefs, relationships and behaviors originated. A much more effective model is to keep the youth in the same home and school setting while providing treatment in a ten or twelve week program which provides intensive services three evenings per week and requires attendance at self-help groups such as Alcoholics Anonymous or Narcotics Anonymous as well as therapeutic, supervised recreation on the other two weekday evenings and during the weekend. Urine testing can be required and parents can be involved in family counseling and family support groups. Here youths are changing beliefs, attitudes, emotions, relationships and behavior in the setting in which they will continue to live and cope. At the end of the intensive treatment program, they can graduate to once a week group counseling and continue with the same peer group in self-help and recreation activities. In addition to having a lower level of relapse, this treatment approach is less expensive than hospital or residential treatment. Tragically, our health insurance carriers and Medicaid do not have a mechanism to fund this kind of treatment.

New Demands on Schools: Schools are being asked to take on new roles which not only involve health education but require linkage and coordination with community treatment agencies in order to identify youth with substance abuse problems, refer them appropriately and cooperate with aftercare when youth return from residential treatment. Schools are beginning to contract with community agencies to provide Student Assistance Programs which bring substance abuse counselors into the school to screen and refer youth as well as educating all members of the school community, including parents. There is a tremendous need for more afterschool activities targeted to the disaffected

youth who have been abusing drugs and alcohol. They have dropped out of sports and traditional school activities and need special "clubs", rap groups and supervised work programs to help them learn ways to use leisure time which do not rely on drugs or alcohol. These youth need a holistic health approach to changing their lifestyle which includes healthy patterns of nutrition, exercise and leisure time activities.

Too Many Agency Resources Devoted To Responding To Bureaucracies at the Federal, State and County Levels of Government: My community agency must respond to multiple separate planning, funding and monitoring bureaucracies to justify and receive funds which we allocate to chemical dependency services to adolescents. Our chemical dependency services provides client data which goes to the National Institute on Drug Abuse (NIDA) for the CODAP data base. We submit detailed quarterly program reports and financial reports for our contract for outpatient counseling slots. We submit a separate set of similar reports for our prevention grant which is under \$10,000. My program director has just told me that the State monitoring agency has told us that we will have separate teams of staff coming regularly to do site visits on the two contracts. We are also receiving county funds to supplement State dollars. We must submit separate applications and separate monthly reports to the county on separate drug and alcohol funds even though all are operating within the same cost center. One integrated report to all four funding sources tracking all funds and reporting program data would be much more appropriate. My agency also has contracts with the Division of Mental Health and Hospitals, the Division of Youth and Family Services, the Division of Developmental Disabilities and local school district contracts for our special education program monitored by the Department of Education. Adolescents in all of these

other service areas need access to substance abuse assessment and counseling. We are attempting to provide coordinated services but must struggle with different contract fiscal years, different applications, duplicative reporting mechanisms and overlapping site visits and monitoring functions.

CPC Mental Health Services, Inc. is facing cutbacks in services in the next fiscal year because our public funding sources are not providing revenue to cover our actual costs of operation. Imagine my frustration to read in the New York Times on 4/17/89 that New Jersey is one of the 10 states who have not even completed applications for this years federal funds for prevention, early intervention, treatment of intravenous drug users or special programs for women. Moreover, they have not passed last year's funds on to hard-pressed community agencies. While administrative delays at the state level often hamper our ability to reach out into the community, I feel that they are in no way a reflection of the desperate need for community programs across the country.

In summary Mr. Chairman, the fragmentation of services to adolescents is a tremendous barrier to helping families get the help they need. The federal, state and county health and human services bureaucracies do not provide incentives for coordination. There are large numbers of children who need substance abuse and mental health services. They are in our schools, our juvenile court and corrections systems. They pass through shelters, hospitals, police stations and other community settings where their problems could be identified and they could and should be referred for treatment. We need to encourage cost effective treatment approaches such as intensive

outpatient services and restructure our funding and reimbursement systems to provide incentives for agencies to switch from more costly and less effective modes of intervention. We need to reduce duplication of effort in planning, funding and monitoring of the same agencies at multiple levels of government. We need to structure and fund services so that an adolescent who finally decides to seek treatment is not left to languish on a waiting list in a community agency.

Under the federal model of a community mental health center, an agency had an ongoing obligation to reassess the needs of the citizens in its service area and propose program changes aimed at meeting high priority needs. There must be a reliable funding mechanism to plan services needs over more than one year at a time so that agencies providing substance abuse services can build relationships with key systems such as schools, mental health agencies, family court and corrections. The fragmentation of service funding and planning must be reduced if we are to reach the increasing numbers of adolescents who are chemically dependent or at risk of developing a dependency.

We know there is a cost to providing effective treatment and prevention services. If services are not available, the costs to individuals, their families and society-at-large which bears the consequences of their dysfunction, will be even higher.

Mr. Chairman, speaking on behalf of the provider members of the National Council of Community Mental Health Centers, we thank you for holding hearings on a topic as timely and vital as this. I would like to add that as a national organization representing providers at the community level, we

believe there is nothing more helpful that this Congress can do than to provide full funding for the comprehensive services available through the Alcohol, Drug Abuse and Mental Health Services Block Grant. We endorse efforts on the part of the Labor and Human Resources Committee (as well as Senator Harkin's Appropriations Subcommittee) to improve mechanisms which assure the speedy and efficient administration of these dollars by the States.

Thank you for inviting me to testify and I look forward to answering whatever questions you may have.

11A:57

Senator DODD. Mrs. Rudd, we appreciate your coming down from Connecticut. Thank you for being here.

Mrs. RUDD. Thank you very much, Senator Dodd.

My name is Leigh Rudd. I am the mother of a teenage drug user who started using drugs at 14 and is now 18 and in recovery. He has been in recovery for 2 years, partially because it took so long to get the right help.

There were so many barriers even after I found out in May of 1987 that there was a serious drug problem with my son. The first barrier was lack of easy access information in the very beginning. Although there are so many drug and alcohol services in my community, there is a serious lack of information about what to do when you are in crisis.

For example, as a family, we had no idea of the severity of the situation. We had no way of getting an evaluation. The town's services are too segmented, too fragmented. We had no central place to go where we could get information, facts on my son's drug profile; each case is slightly different.

I had to network with other unfortunate parents to get even the basic information, and they always said the same thing—that experience was their teacher. Every parent's story was the same. I talked to one parent last week whose son committed suicide because the father did not have the basic information that drugs and suicide go hand-in-hand.

We lost months of proper treatment because after days of phone research, we were advised to go to a drug therapy agency in town. This very agency, because of the confidentiality law, did not let me know that my son was high-risk depression because of drugs and that he was still using drugs after 4 months of weekly drug therapy.

I asked the agency to do a drug test, and then they refused to confirm that the test was positive. During this 4 months, we not only lost valuable time, but my son was also severely depressed, and no one knew why. His therapist did not share the risk factor, which I believe was both negligent and possibly illegal.

Second, another barrier to treatment was the time it took to (a) realize that a rehabilitation facility was essential, and (b) find an adolescent unit that specialized in drugs—and I underline the word "adolescent"—(c) research the insurance factor, i.e., were we covered. Please note that when you are dealing with an emergency, every hour, every day is crucial. Nine-to-five information is just not acceptable when your child could die.

You cannot imagine how terrifying it is to be told that, "The admissions office is closed; call back tomorrow."

Once I located the rehab facilities, I was told there were no immediate beds. In every rehab situation, I was told beds would take anywhere from 3 days to 2 weeks. This was an emergency, and I was told I had to wait. In the meantime, my son could have died.

The next problem was the insurance, which only paid 80 percent of the \$20,000 per month of the treatment fees.

Senator DODD. Twenty thousand dollars a month?

Mrs. RUDD. Yes.

Also, we had to put down a deposit, which we did not have. We had to scrape together every penny we had because at that time we

were having financial problems. Then there was the insurance cap, which means that very often treatment is terminated prematurely.

Another barrier for us was the lack of extended care treatment, i.e., halfway houses for—and again I underline the word—adolescents. It is a well-known fact that adolescents require specialized and longer treatment than adults. Because we did not have a halfway house in our area, my son had to go to another part of the country. We need extended treatment centers in all areas of the country.

It is also a well-known fact that family therapy is an essential part of recovery. Not many families can afford to send their kids to a halfway house in another part of the country, nor can they afford to partake in family therapy with their child in another city—and I agree that family therapy is essential.

Not only do drugs tear a family apart, but the current treatment process tears the family apart even further.

Fifth, again, although the recovery process which, for an adolescent, can take months or even years, I never had the information I needed until we were in crisis. For some reason, I could never find anyone except another parent who could give me the facts on the phases and stages of recovery—and there are phases. I only knew about the phases after I had finished one phase and was already into the next phase. In my case, each phase was a life-threatening situation, an emergency. Until you have a child with a drug problem, you have the impression that it is will power and "Just Say No" to drugs. This is totally false. I have met so many parents who say the same thing.

We are talking about a disease here, a terminal disease, and a few hours of drug therapy are not going to cure a terminal disease. Would we do that with cancer?

Sixth, of all the barriers, though, denial has been the worst—and I mean denial in all areas—parents, school administrators, law enforcement and community. I have heard so many people ask, "What drug problem?" I think people are generally afraid—afraid to admit it, afraid to confront it, and afraid of the embarrassment. Part of the fear, of course, is that it is such a very serious problem. It is an epidemic that is killing our children. And by association, the violence brought on by drugs is killing innocent people every day. It is an epidemic that is killing our adolescents directly, through overdose, and indirectly, through suicide and car accidents. Our suicide rate goes up as drug use expands. They go hand-in-hand.

In my town's school system, we have drugs in the high school, in the junior high school and in the elementary school. Children as young as 9 and 10 are apparently experimenting. These drugs are not confined to marijuana. Cocaine and LSD are commonly used in high school, as well as crack. Drug trafficking is done on school campuses; the kids are drug dealers. But we are all in denial.

However, as it gets more serious, it gets harder to deny. I had incredible support from so many people in my town in reference to this hearing. So many people said, "Try to explain what a crisis this is, that we need help, we need legislation, we need funding." So the denial is gradually changing. That is an important step.

Seventh, part of this denial factor has been the impossibility of the crucial re-entry phase of the drug user into the community. How can you take a drug-addicted adolescent after rehab and put him back into a community riddled with drugs?

On two occasions, my son tried hard to stay straight against impossible odds. He says he was offered drugs in school every day. After 5 months, he succumbed to temptation and ended up in a hospital once again. His doctor told him that he had 2 weeks to live if he continued using drugs.

We need a drug-free system for these kids who are trying to stay straight. I have watched so many kids try and fail because we do not have adequate support systems.

My son went from being the all-American, popular, bright athlete, MVP, team captain who got good grades to living in a vacant lot at the age of 17. He is now in recovery in a halfway house, but he had to drop out of high school to get straight. His biggest problem right now is trying to find a drug-free environment so he can continue his education.

In closing, I want to say that as a parent and as a citizen of the United States, I implore you, Senator Dodd and committee members, to effect legislation to help our dying American children. I came here today representing millions of mothers across the country who need your help. Please stop our children from dying prematurely from drugs and suicide. This is the future of our country that we are killing.

Thank you, Chairman Dodd, ladies and gentlemen.

Senator Dodd. Thank you, Mrs. Rudd, very much.

I might be otherwise pessimistic about the outcome of this fight, but I've got about the best allies I know of in the world, and that is parents like yourself. Sticking to it as long as you have—I do not know if you heard young Michael and Lisa, but again, her mother and his parents just did not quit, they did not give up. So I commend you for your efforts as well.

We have heard about the inadequacy of funding levels, clearly, in the absence of any real focus on the adolescent problem. As I said this morning at the breakfast we had where we viewed the Home Box Office film that will be available on helping parents become more familiar with the problem that they face, as well as others in their neighborhoods and communities, we want to try and hold some additional hearings on the subgroups here, because I think the tendency is to lump everybody together and to think it is the same problem. It is obviously not. So we are going to see what we can do to get some additional assistance for these treatment programs.

I am impressed with the fact that there are a variety of programs available out there and again, based on the degree of the substance abuse and the longevity of it, various programs that may not be as costly can be effective.

I am staggered by \$20,000 a month—we heard nothing like that statistic. I thought you had just misspoken. We heard Dr. Rosenthal talk about \$18,000 a year. So you have obviously been in a very intense program with your son.

At any rate, let me tell you we will keep at it—did you have a comment you wanted to make, Ms. Olson?

Ms. OLSON. I was going to comment that the program she is talking about, I am assuming, is an inpatient program and is most likely a private, for profit program, and most of those are running probably \$20,000 to \$25,000 for a month to 6 weeks.

If you look at publicly funded programs, however, you are looking at a completely different situation. In the privately funded programs, the average daily rate is between \$300 and \$500 a day in Missouri; our highest publicly funded adolescent program is \$71 a day.

Senator DODD. What is the waiting list on that?

Ms. OLSON. All of our programs have waiting lists. I cannot tell you specifically for that one program. We are at an all-time high in terms of our waiting lists. Our average last year for our entire system—and again, it is very fluid, as was said before—the average was 750. This year, already, our latest data show that we have over 900 on our waiting list, and they continue to grow. And we have continued to provide more services. It is not like we are staying the same and providing less. We are providing more and more services, but the numbers on our waiting list continue to grow as fast or more rapidly.

Senator DODD. Dr. Johnson pointed out that surveys of high school seniors concerning alcohol and substance abuse, the findings indicate a downward trend. The problem is that you've got too many kids living in vacant lots before they are seniors, so they never show up statistically.

Yes, Mrs. Rudd?

Mrs. RUDD. I just wanted to speak for a second to the private care. It is true that this was a private care facility, but I discovered that it was kind of a "Catch-22" situation in my case, because we fall into the middle class. So yes, we had insurance which paid 80 percent, but when we started to run into financial problems, I found that I did not qualify for the public funding, and that I was in the middle—I could not afford the private care at a certain point, but then again I made too much money to have the public care. So there was a certain point that we could not get any treatment.

In fact, this week, we are having to sell our car to be able to continue the payments for my son's halfway house.

Senator DODD. Once again, middle-income folks who fall through—and they talk about a "crack"; it is not a "crack"; it is a canyon. I hear it every day with one thing or another, whether it is child care or whatever else, that God help you if you end up paying for these programs, and you never can qualify for them. It is an age-old problem.

Mrs. RUDD. There was one other thing that I wanted to say. I feel—and I do not know the statistics—but I instinctively feel that 6 million must be low, because I know for every one of the kids that I know who are in treatment, each one of them has 10 or 20 or 30 friends, or 40 friends, out there, who are still in the system, who are still using excessively way beyond what you would call social use, and should be in treatment, and haven't even gotten to the point of knowing that they have a problem.

Senator DODD. Let me ask you one last question, all three of you here. In your opinion, what is the greatest obstacle to getting ado-

lescents into treatment programs? Let's start with you, Mrs. Rudd. What do your friends tell you who are going through similar things?

Mrs. RUDD. Well, I think that the single biggest problem once you have gotten beyond the step of knowing—because that is a whole other issue; in my case, I was lucky because my son told me—but once you get beyond that, the single biggest difficulty for me was, as I said, easy access information. If we have a fire in our house, we know that we have to call 911. But I had no way of finding out what to do except by what I call underground networking with other unfortunate parents, because they were the only ones who seemed to know.

We seem to be paying, in a sense, lip service. I mean, everyone means well with all the services and agencies, but when you are the parent in crisis, and when you are the drug user in crisis, you need help day and night—if it is 3 o'clock in the morning, or wherever it is, you need help immediately. And as I said, minutes count, hours. On many occasions, I had my son sitting next to me, crying and shaking, "Mom, get me help," and I had people saying to me, "Call back tomorrow" or so-and-so is on vacation.

So one of the biggest things that I felt was there was no one I could turn to. There was an agency here and an agency there, and yes, everyone meant well, and someone would say, "Well, you should call so-and-so at this place," but you know, when you are in crisis, you do not have the time to network.

So that was my biggest personal frustration.

Dr. WURMSER. I would just like to reinforce what Mrs. Rudd is saying. I think we need coordinated systems of care. We need 24-hour emergency response capability so that parents have someone they can call.

Senator DODD. What about these hotlines I hear about on television all the time? I am single, with no children, so I can sympathize, but I cannot empathize. But it seems to me I am always listening to someone saying if you've got a problem, call this number immediately. I presume you have tried some of those.

Mrs. RUDD. Well, let me tell you something, and this is, I would say, sadly amusing. But last week, because I knew I was coming here, I went through the same process that I went through 2 years ago when I found out my son had a drug problem, just to make sure that 2 years ago I wasn't so upset that maybe I missed something. I did call various hotlines that you are referring to, and it was the same thing. And again, everyone is well-meaning, but it is the same process—well, you need to call so-and-so, and then you call so-and-so, and then you need to—I mean, there was not a single place where I could go for information, although I understand people are trying to create a centralized database where you can go.

Senator DODD. Dr. Wurmser.

Dr. WURMSER. I really just wanted to reinforce that point, that parents are in crisis when this happens, their families are in crisis; they need an effective professional evaluation. There are volunteer services that can be very helpful, and they can be very supportive, but they cannot work in isolation. This has to be a coordinated effort, so the 24-hour services need to be there. The medical serv-

ices need to be there, the urine testing needs to be there. It has to be a comprehensive package of services if we are going to do this effectively.

The other part is that we are trying to work very hard on the prevention and education end of it, and the frustration for us is that we have been effective. We are starting to get schools identifying students and sending them to us earlier. We are starting to get kids walking in occasionally and saying, "I am in deep trouble, and I need help." We are starting to get parents to bring their friends and say look, my son had a problem, and I know that my friend's kid is having a problem, and we have walked in with her to give her moral support. They need to get into treatment, and I have a 4-month waiting list.

Senator DODD. My sense of it is from what Mrs. Rudd is saying—we get all the legislation—and God knows, I have supported almost all of it—that requires truth-in-labelling so the consumers are better informed as to the ingredients of the things they consume. First of all, you have got to have the vision of a 10-year-old to be able to read it, and then if you can read it, you cannot pronounce them, and if you can read them and pronounce them, you do not know what the devil they are. In a sense, I get almost that same sense that there seems to be this proliferation of well-meaning, highly-knowledgeable, well-educated, talented people out there in this field whom you might as well be speaking Greek to. I mean, when you are sitting there, and your child is shaking and crying and weeping as yours was, and all you want to know is what do I do, where do I go—it is that groping, grasping kind of sense of someone who would just say, "Don't worry, and here is what we do."

But my sense is of a lot of jargon that kicks around, and it just gets to people. That is the frustration, and I think there is an awful lot of it, and it needs to be pulled together in a synthesized, clear way where someone at any hour of the day faced with this crisis with a child can call up and here is where you go, right now, in your region, your area, and there is someone waiting there to see you and see your children.

And without getting into all the gobbledygook that a lot of people do not understand who function at one level, it seems to me is what is really needed. This is at least the first step, as I see it, that peace of mind.

Ms. OLSON. I think you are absolutely right. It seems to me that there are a couple of problems, and there is no good single port of entry for a person to access, and a couple of things happen. You may contact a program, and they are full, and they have a waiting list, and they will have to say, "I am really sorry, but we can't admit you."

A number of the programs will help you try to contact someone—

Senator DODD. Yes. "However, here are three things you can do over the next 2 weeks."

Ms. OLSON. That is right, or help you to contact another treatment program or whatever. But that is even a second-best kind of thing.

The other thing is that you may contact a program, and they are going to tell you that what you need is what they provide, which may not necessarily be what you need or what the person you are seeking help for needs. So you need a place where you can make a contact, you can go there, you can see somebody, they can evaluate you and give you a sense of what kind of care you need and then help you navigate that system. We do not have that, and that is something that I think is absolutely essential for the consumer to access our system. It is very, very difficult to do.

I do apologize to all of you for making you wait so long.

I am sure there will be additional questions from other members. I think it was very helpful today just to get the numbers sorted out a bit, because I am always leery of the numbers game. So that has been very, very helpful.

I have had a nice conversation with Dr. Johnson, and I want to particularly commend her in her absence. It is not fair in many ways for those of us who are Members of Congress to sit here and ask these administrators how much they would like to spend on a program, and invariably there is someone from the Office of Management and Budget sitting somewhere out in that crowd, and God help them if they announce in here that they would like "x" amount more. I can tell you, before they get back to their office, there is a phone call waiting for them, telling them to keep their mouths shut. They are not supposed to be sitting there, announcing how much they would like to get.

But Dr. Johnson was very candid, I thought, and very interested in seeing us do more, and she is very confident that some of these model programs we have been working on are actually proving to be tremendously successful; that they are going to need a little bit more time before we can get the States and some of the private organizations to come in and start to really help fund some of these things and keep them going, because particularly in the inner cities, there are a lot of these programs that would never, never work or even be tried were it not for some of these efforts, for these high-risk kids who drop out of school, and there aren't the churches, there aren't the schools and other things there to really fill in.

So we are going to have to really take a good, hard look at not just them, but people like the middle-income families and others to see to it that we make this stuff available to people and can get some good, decent treatment programs around the country available—and at a cost that people can afford—and obviously to get involved earlier, and detection, and all these other things that we have to do to cut down this demand.

Ms. OLSON. Let me give you just one more piece of information in terms of the difficulty in trying to implement that. With the Omnibus Anti-Drug Abuse Act and the block grant, we received approximately \$1 million new moneys in Missouri, and we are mandated to do about \$2 million worth of new programming. That means we have to take \$1 million away from something that was already existent and already funded to meet new mandates.

So it becomes a real "Catch-22".

Senator DODD. I hear from the governors all the time on that issue.

Ms. OLSON. It is a very, very difficult situation.

Senator DODD. Yes, I understand, and I appreciate it. I have a child care bill I am trying to get enacted, and one of the major complaints about it is that we ask the States to do some things there, and they do not want to spend the money on it. So we have got to try and figure out a way in which we can not ask—because in fairness, it is the Federal Government asking States and localities to do things, mandating that they do things—and we have got an obligation to try and help reduce that cost to some degree. So I hear you. Your governor would love you for saying that.

Again, my thanks to all you and to the previous witnesses. Your testimony has been very helpful this morning, and we hope to be able to follow up with some meaningful assistance in this area.

Thank you, Mrs. Rudd, as well, for coming down.

The subcommittee will stand adjourned.

[Whereupon, at 1:55 p.m., the subcommittee was adjourned.]

